SEAPRAP RESEARCH
REPORT NO. 68

"TOWARDS A BETTER WAY OF LIFE": A SOCIAL WORK EXPERIMENT WITH FAMILIES OF IMMIGRANT LABOUR ORIGIN IN SINGAPORE

PAVALA RANI THANGAVELU
Singapore

November 1980

A report of research undertaken with the assistance of an award from the Southeast Asia Population Research Awards Program (SEAPRAP), Institute of Southeast Asian Studies, Republic of Singapore

(an edited version)

ACKNOWLEDGEMENTS

I am grateful to several people who made this study possible. First, I would like to acknowledge the sponsorship of the Southeast Asia Population Research Awards Program (SEAPRAP) of the Int'l Development & Research Centre and Ford Foundation without which this study could not have started. My special thanks are due to Dr. Pedro Flores and Dr. Wilfredo Arce (Project Co-ordinators of SEAPRAP) who gave much support and encouragement to complete this study.

I would like to record my gratitude to Professor Ann Wee, Head of the Social Work Department of Singapore University, who initiated this study and facilitated both the sponsorship and the conversion of this study into a thesis.

I am deeply indebted to Professor Peter Hodge, Head of the Social Work Department of Hong Kong University, who unstintingly supported, helped and encouraged me to complete my work.

To my supervisor Mrs. Margaret Carter, of the Department of Social Work of Hong Kong University, I am truly grateful for the invaluable guidance she gave me, especially in the methodological aspects of this study and for her persistence and rigour in ensuring that this study met academic requirements. My appreciation is also due to her for the understanding she showed in my times of difficulty.

I am very grateful to Mr. Barry Sullivan who gave much of his time and expertise to comment and advise on the presentation of this thesis.

I would also like to thank Mrs. Nancy Rhind, of the Social Work Department of Hong Kong University, for acting as the independent judge in rating the study's population functioning levels, an essential aspect of this study.

My thanks are due to Ms. Emily Li who was extremely helpful in typing the drafts and to Ms. Wyman Wong for kindly typing this thesis.

This thesis is dedicated to the people who formed the study population. Without their acceptance and trust this study would not have been possible.

Pavala Rani Thangavelu
Singapore
November 1980

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

CHAPTER I

INTRODUCTION

The people involved in this study came to my notice when I was working as a Probation and Aftercare Officer in Singapore in 1970. At that time, I worked in my official capacity with some of the men, adolescent boys and children from this group, as they were among my caseload. While working with some of them on an individual basis, I gathered only bits and pieces of information and impressions of these people. It was then that I became aware of the problems these families faced and the social context in which they lived.

In 1973 I made a systematic study of their social circumstances and the problems they faced as a group. In that study I set out to find the factors and circumstances that influenced their decision making process in the area of family planning and contraceptive behaviour. Though it was a study of only a small sample of that community, by then I was familiar enough with them to observe that some findings in that study applied to a greater number of families outside the sample but within that community. Disorganisation in social functioning, lack of information and resources, low self image, to name a few, came to the surface in the findings.

There were mainly two reasons that prompted me to work with these people. First, I am an Indian of immigration origin, too, though of a more fortunate history of arrival in Singapore than that of the study population. My predecessors came to Singapore of their own volition and arrived in Singapore under far more favourable circumstances. However, I belong to the third generation of Indians born in Singapore. I consider myself a Singaporean and know of no other home than Singapore. My social groups consist of non-Indians, too, and my values are those of a Singaporean. Nevertheless Singapore being the society it is, I did not have to lose my ethnic identity, language or culture. Thus though different in some ways to the people studied in this experiment, I could nevertheless identify with some of their cultural, traditional and religious beliefs and practices. It was this I think that predisposed me to want to work with these people.

Second, being a social worker I believe and know that given support a sub-group such as these people could integrate with the society at large and achieve more satisfaction in life.

The opportunity to put this conviction into practice came with the sponsorship of the South East Asia Population Research Awards Program (SEAPRAP). This organisation financed what was to be a service project to motivate the client group towards family planning. Thus the initial planning of this experiment was geared towards it being a service project which would run for a year. However, on the initiation of Professor Ann Wee of the Social Work Department, Singapore University, this project developed into an action research. By this time, I had come to the conclusion that in order to promote family planning behaviour or for that matter any other aspect of family life, social functioning must as a whole improve to facilitate a family in putting insight into action. Thus with the blessings of the SEAPRAP the experiment was started. The objective still was for this project to be not only an experiment but also to be of service to those people.

CHAPTER II

A HISTORICAL AND SOCIAL PERSPECTIVE

In order to appreciate the sub-culture and the nature of the problems facing this study's client group in present-day Singapore, it is necessary to know not only about their immediate and particular socio-cultural environment as it is today but to take a wider historical and social view of Indian settlement in Singapore and the Malay Peninsula. A detailed description of the client population will be given later but for now I will focus on the events that led to the coming and settlement of Indians in Singapore.

The Indian migratory movement into Asia has to be viewed in two different time spans as the two patterns differed greatly. Most documentation on the early history of Indians in Malaya does not deal with Malaya and Singapore separately, so that whenever Malaya is mentioned in this study, it implicitly includes Singapore.

The Traders

It is not possible to trace the exact date of the arrival of the first Indians in Malaya. However the earliest evidence of an Indian presence and influence in Malaya dates back to the fourth century A.D.[1] The Indians at that time had initiated trade to meet their own needs and interests. They came out to Malaya to secure gold, spices and local produce. As their journeys home were dependent on the seasonal monsoons, waiting for the change of winds resulted in the establishment of Indian settlements along key points of trade, but it was only in the 9th century A.D. that a strong Indian political and cultural influence began to be felt. The expansion of the Sri Vijayan Kingdom established major trading systems, and throughout the 11th and 12th centuries A.D. Indian cultural influence seeped into the Malayan states as religion, concepts of court, administrative institutions, rituals and ceremonies were all strongly moulded by the Indians.[2] By about this time, distinct Indian settlements were already evident in Malaya. For instance, "a suburb of the city called Kampong Kling was occupied by Indians who were employed as

officials, teachers, petty traders, goldsmiths and craftsmen."[3]

This stage of the Indians' hegemony in Malaya came to an end in A.D. 1511 with the Portuguese conquest of Malacca, a major Malayan trading post.[4] The Portuguese monopolistic trade policy drove many merchants from Malaya, and this process was accelerated by the Dutch when they captured Malacca in 1641. The Dutch, for the same reason as the Portuguese, strove to eliminate all competitive foreign interests. Thus the economic power and social presence of the Indians dwindled.[5] To sum up the Indian presence at this stage:

> "with little exaggeration it has been said of Europe that it owes its theology, its literature, its science and its arts to Greece; with no greater exaggeration it may be said of the Malayan race that till the 19th century they owed everything to India: religions, a political system, mediaeval astrology and medicine, literature, arts and crafts."[6]

The Labourers

The stage for the second act of Indian peregrination was set with the foundation of Penang by the British in 1786; the subsequent establishment of the Straits Settlement in 1826 and the formation of Singapore as the capital in 1832. Though many Indian traders had by this time left Malaya, mercantile communities were still present and growing there. Nevertheless, the difference, as Arasaretnam says, between pre-British rule and British colonial rule was that "in the former periods India supplied goods, in the latter, primarily labour."[7]

An enormous need for manpower emerged in Malaya, when under the British new and large developments in agriculture and other labour intensive ventures were being established. During the early 19th century, the economy of India, a vast country with an equally vast population, was breaking down. With little economic expansion to solve massive unemployment, her capacity to support all of her people was diminishing. Thus India, then a British territory also, appeared a suitable place from which to recruit labour.

The wheel which set this migratory movement in motion was the indenture system which rolled through the century to transport large numbers of Indian labourers into Malaya. As this study concerns a group of Indians who are still primarily labourers, most of whom are descended from the plantation workers of Malaya, it is pertinent to discuss the indenture system, the causes of emigration and the life-style of indentured labourers.

Economic deprivation on the home front and economic opportunities abroad were the "push and pull" factors responsible for emigration. The indenture system was a process whereby an employer of labour placed an order for a number of labourers with an agent based in India, who, on receiving these orders, sent his contact men to the villages to obtain the recruits. These recruits were required to sign a contract of indenture valid for five years. During this period they were not allowed to change employer or employment, and on completion of the five year bond, they could be signed on again or released from the indenture.

The main goal of the indentured labourers was to seek their fortune and return home as rich men. What actually materialised was quite to the contrary, for though the contracts were for five years, due to the pressing need for manpower, the employers had several means of retaining the services of the labourers for longer periods. Wages were ludicrously low, without relevance to the cost of living, and the inclusion of innumerable items of expenditure to the labourers' charge kept them in perpetual indebtedness to their employers. Thus there was no way of getting out of the indenture. Recruitment under this system has been called "organised kidnapping".[8] The impoverished and depressed in India were easy prey and the transportation of these already weakened beings under inhumane conditions rendered many susceptible to exploitation. In addition to these cruel realities, their personal and social lives were bleak. Mostly single men were recruited. The recruitment of women was not easy and none at this stage emigrated as family units. Hence a chronic imbalance existed in the sex ratio of these emigrants and family life as such was non existent.

Towards the end of the 19th century, a less brutal system of recruiting through the "Kangany"* evolved. The Kangany, usually a foreman or labourer of some good standing, was sent to his village to recruit from his people. This considerably cut down the abuses and inhumane process of the indenture system and opened up opportunities for the migration of families, a factor which influenced the settlement process of the Indian labouring community.

The social lives of the indentured labourers were as hard and as bleak as their working lives. Little has been documented of their initial physical environment. However, in 1912, improved housing was introduced and quite fittingly called "lines", consisting as it did of "long buildings roofed with a local palm called attap, or sometimes with tiles or corrugated iron, which was divided down its length by a partition not reaching the roof and partitioned into rooms back to back, each occupied by a family."[9] The buildings were erected on stilts and the room below was used for cooking and storage. Water and communal toilets were provided for an area. Tinker observed that: "even the best labourers' dwellings have a woebegone, bedraggled air about them. They may have been standing for seventy years, but they seem to have a temporary appearance."[10]

Health was poor and medical facilities minimal. The government took no responsibility for providing education, though in 1923, at the request of the Indian government, it was stipulated that schools be established in estates. With the stipulation minimally implemented, the authority's responsibility ended. The schools were often dilapidated buildings, and to minimise expenditure, clerks, Kanganys and literate labourers were put to work as part-time teachers. In the 1920s children could start work on the estates at the age of ten, and in their poverty stricken state this was what most parents required their children to do. The appalling living conditions and the lack of education and leisure activities took an inevitable toll by way of social problems. One of the long standing problems was the practice of toddy drinking. Toddy is an

---

*"Kangany" - A Tamil word that literally means supervisor or foreman of a group of labourers.

alcoholic drink tapped from coconut palms which are common in Malaya and Singapore. One of the attractions offered to the labourers during recruitment in their native villages, where liquor was not so readily available and where the hidden controls of village and caste norms were against alcohol, was the cheap and plentiful availability of toddy in Malaya. After the hard life on the plantations, with nothing more than the "lines" to go back to, the labourers found toddy a sedative and a release. This indulgence was helped along by estate managers establishing toddy shops and even advertising the easy access of toddy as incentives to attract labourers to their estates. The habit became so widespread that the image of an Indian labourer was that of an inveterate drunkard; an image which still persists and which can be seen among the client population of this study.

In addition to the problems that they faced after getting to the new land, these immigrants brought with them some other equally debilitating problems from their culture at home. The 1931 Madras census reported that more than a third of the emigrants belonged to the "untouchable" caste. Though the caste system was not so rigidly imposed or practised in Malaya and Singapore, the "untouchables" were nevertheless not easily allowed to forget "their place" in the larger Indian community which consisted of different strata of castes. The many physical and psychosocial deprivations suffered as indentured labourers did.very little to boost their already low self-image. The transient mentality so typical of these Indians served only to aggravate their feeling of inferiority. This seriously impaired self image has been perpetuated and shows up often as an obstacle to mobility among some of the client population in this study.

Little in history really helped this group of immigrants in any meaningful way to overcome the predicament brought about by their unfortunate origins. The indenture system was abolished in 1910 and until 1938 the Kangany system was the main channel of labour supply. The main reason for the abolition of the Kangany

system was the Great Depression of 1929-32 which diminished the demand for labour. To add insult to injury, during the depression the surplus labourers were thrown back to India like "sucked oranges",[12] for after all they were imported only to work on estates and render other services.

I am discussing the origin of the Indian labourers at length as their descendants are the subject of this study. This detailed discussion is to demonstrate the influence the past has had on the client population's life-style in modern Singapore. Singapore now, as then, does not only consist of these Indians. There are other groups of Indians whose history has been more fortunate. As mentioned earlier, the first stage of Indian migration brought out the mercantile Indians and as early as the 1880's, western educated Indians were employed to man the administrative services of the colonial office. Professionals, businessmen and the priestly class, to name a few, joined the migratory movement in the 19th century, settled in Singapore and developed into communities. There arose, therefore, two classes of Indians with contrasting life-styles. Towards the end of the century, some convergence did take place between these two entities and with later generations the gap is narrowing.

The Process of Integration

With independence from the British, not only did the two groups of Indians have to integrate but the Indians as a whole had to merge into the mainstream of Singaporean society. By about the 1950s, the Indians who had for long shown migrant and transitory characteristics began to demonstrate greater evidence of permanency. The 1957 Malayan census indicated that two-thirds of the Indians were born locally and the 1947 Singapore census came up with similar statistics. In Singapore today, Indians constitute 6.9% of the population. Most third and fourth generation Indians born in Singapore, regardless of educational, occupational or social status, consider Singapore as home. If there is any reference to India at all, it is only to religion and the arts.

To be a citizen of a country is to belong, to have roots, to be cared for and to care. Citizenship qualifies one to avail oneself of the whole social system. A citizen gets top priority to reap the benefits of the social and welfare services. When Singapore gained her independence, she offered citizenship to those who had been living and working there. Many chose to belong. The transient Indian is no longer common in Singapore. But there are those who chose not to belong and others who procrastinated for just too long. These "non-belongers" are heavily represented in the labour force of the city cleansing, public works and port services. The more economically successful are to be found in small to big private businesses with some in professional jobs. This is in contrast to locals who are found in a more balanced proportion in occupations ranging from professionals to labourers. One fairly recent study[13] has grouped the Indians in Singapore today into five categories, namely:-

1) The Singapore citizen who has no ties with India and who sees Singapore as his home and may have some interest in India as his homeland.

2) The Singapore citizen who may still retain ties with India and may visit India as his homeland.

3) The non-citizen who is not eligible for citizenship but who wishes to remain in Singapore.

4) The Indian who sees India as his home and intends to return to India.

5) The non-citizen who is in Singapore on a work permit and who makes his intentions clear.

A factor important in determining life-style is the decision as to which particular group the Indian has chosen to belong. Those whose ambition is to return to India cramp their life-style to save enough to return home, and furthermore, adhere to the cultural and social practices as upheld in their native villages in the hope of avoiding dislocation if and when they return.

As described earlier, the labourers' predecessors started off as an isolated group living within estates and labour "lines". As they were Hindus there was no common religious ground upon which to meet other ethnic groups and their caste orientations restricted socialising with Indians of other social backgrounds. In addition, their history of educational deprivation had handicapped them severely in terms of upward mobility on the occupational ladder. Such stagnation provides them with little motivation to stay and their dream of "home" in turn further isolates them. Conversely the Indians who have identified with Singapore and made it their home spend their resources on making life comfortable and stable. Without the pressure to adhere to prohibitive rituals and taboos, they are able to shed their communal identities for better integration. Those who wish, perhaps a little too late, to be citizens but cannot are the ones caught in a dilemma, for they have nothing to go back to, yet are unable to enjoy the full rights of Singapore citizenship.

From a purely impressionistic view, I would say that the first group of the five categories listed above consists mainly of educated and socially mobile Indians. Those who still nostalgically consider India as a home are predominantly elderly people with fond memories, and those who for reasons such as isolation, as previously described, and low educational level are unable to integrate fully into the society at large. Due to their sluggishness in accepting Singapore citizenship and a desire to retain Indian citizenship, many people most in need of state help have denied themselves much, because they have to pay more for social amenities and stay low on the priority list for many opportunities, such as better employment.

There is also the distinct group of low income people who, initially planning to return to India but never able to save enough to do so, are forced to remain in Singapore. Their children were born in Singapore and therefore are under Singapore's jurisdiction. Even if these children were allowed to leave

Singapore, almost all do not want to. So, to secure facilities for and to be with their children, the parents have to take on Singapore citizenship. Still cherishing the hope of returning to India, these people have evolved a pattern of life moulded strongly by indecision. The conflicts engendered by this state are a very important consideration in studying the life-style of the client population of this study.

In conclusion, this group, whose lives have been shaped by history, has changed in many ways from being the original indentured labourers but nevertheless the influence of their origins remains strong. Those who came as indentured labourers have been exploited by outside forces which crippled their dreams of returning home with their pot of gold. Their descendants are still labourers, still with little hope of returning not because they are tied by a contract but because of their own inadequacies - inadequacies nurtured by the history of their arrival, their life under the indenture system and the habits and values they formulated for themselves from their experiences. The Indian labourer now receives a relatively decent wage sufficient only to have an adequate life in Singapore but insufficient to remit money to India. He is no longer a bachelor living in a cheap tenement with his family in India; he now has to meet the cost of supporting them in Singapore. His inclination, however, is still to look back to his roots in India and thus is not very concerned about his home in Singapore. He cannot afford to own his roof anyway. He makes little use of the social order in Singapore, resorting to "Panchayats" (meetings of elders of the community) to resolve quarrels and breakdowns. He holds back on personal comforts to save his money, but cannot nevertheless resist spending some (or most) of his wages on "toddy" which he was orientated to drink on the plantations. What he earns in Singapore is more than he can earn in his village back home, thus he is satisfied if his sons can earn as much as he can, for the comparison is not between his sons and other youths in Singapore but with those in India.

His previous history and present situation on the whole show him to have low aspirations in the Singapore context. He has not been able to shed the subservient self-image of an indentured labourer. Documentary evidence, as mentioned earlier, indicates that some of these immigrants were from the lower rungs of the caste system which in itself had socialised them into feeling and being subservient. In India they and their predecessors lived in their villages amongst themselves within their subculture and in Singapore they lived in the same way. Little wonder that this group of immigrants did not do much to better their lot. Or perhaps to be more realistic, they lacked the resources to do better. More affluent and educated Indians in Singapore have over-shadowed this group. The notion was, and still is in some quarters, that the Indians have integrated themselves well in Singaporean society. Indians as a whole have established themselves sufficiently to exert considerable influence on the political and social systems. True as this is, not all have achieved this integration.

Those who have not constitute the target group for this study. Until late 1975, this group of labourers lived in their one room-communal kitchen and toilet quarters much as they did in the 1930s. They were just as isolated, both physically and socially, living in enclaves. Now they have been rehoused in the superior housing estates of Singapore, a fact which exposes them in more ways to a larger section of society. It is never easy, one must admit, to meet all the sociological requirements of resettlement and so for the one good reason of preserving community spirit and sense of belonging, these people have been rehoused together in the same estate in the same blocks and on the same floors. The question is, in so doing, has yet another enclave been created? Has the "ghetto" culture been transplanted into fresher soil?

Environmental factors have played a formidable part in keeping this group from achieving their potentials, though it must be recognised that amongst the group as a whole, there are those who have been socially mobile. Better housing is but a prerequisite to a better quality of life. What most people fail to see is that this

group with its history and culture needs that little more attention and needs more than mere rehousing to enable themselves to lead a satisfactory style of life. Some may say that the people from whom my client population is drawn constitute a very small group emerging from an unfortunate past and that the following generation will surely be different. But my earlier study indicates the sad signs of their children perpetuating the same values, aspirations and life-style.[14] These young people no longer look to India as home nor do many aspire further than to be a labourer. My percept is, if the labourer was left on his own, in his enclave of home, values and expectations even when the last trace of the indentured labourer fades, his off-spring would perpetuate his low aspirations and self image. This phithis caused by economic stagnation and cultural dissociation surely should not be allowed to continue.

Reference

1. S. Arasaretnam, Indians in Malaysia and Singapore, (Bombay, Kuala Lumpur 1976) p. 3.
2. Ibid, 1976, p. 5.
3. Ibid, 1976, p. 7.
4. K.S. Sandhu, Indians in Malaysia, Immigration and Settlement 1786-1957, (Cambridge 1969) p. 2.
5. K.S. Sandhu, 1969, p. 6.
6. Winstedt, R.O., "Indian Influence in the Malay World", Journal of the Royal Asiatic Society of Great Britain. (London 1944) p. 183.
7. S. Arasaretnam, 1976, p. 1.
8. J. Geoghegan, Emigration from India. (Calcutta 1873) p. 63.
9. S. Arasaretnam, 1976, p. 63.
10. H. Tinker, The Banyan Tree, (Oxford 1977) p. 53.
11. Census of India 1931, Vol. XIV, Madras, Part 1, (Madras 1932) pp. 87-88.
12. U. Mahajani, The Role of Indian Minorities in Burma and Malaya, (Bombay, 1960) p. 115.
13. F. Nayagam, "Little India" (Singapore University, unpublished dissertation, 1970).
14. P. Gopinathan, Towards an Understanding of Family Planning Behaviour, (Singapore University, unpublished dissertation, 1974).

CHAPTER III

THE RESEARCH PROBLEM

The research questions

A central issue, or hypothesis, in this study is that a change of environment alone (in this case rehousing) may not be sufficient to greatly improve the quality of life for a low income multi-problem family. In this case, prior knowledge of the client population led me to conclude that, in addition to re-housing, they would need some form of social work intervention to enable them to move towards a substantially better life. It is true that the environment from which they moved largely contributed to their disorganised living and it is expected that the move alone would bring some change in their lives. The question is, however, to what extent can environmental change per se affect other areas of social functioning?

If the answer is "very little" another issue emerges, namely can social work intervention, introduced parallel with or consequent upon re-housing, help in any way to raise levels of social functioning that will bring about a more satisfactory way of life?

This study sets out to examine these issues. First, whether environmental change in itself can precipitate changes in self-image and aspirations which in turn will lead to a more organised and satisfying pattern of life. A life in which planning for the future is seen as part and parcel of living. Second, to examine what type of social work will enable families to adequately solve their varying problems.

It should not be difficult to appreciate the emphasis on living conditions for this client population when their situation is seen in its historical and social perspective. My initial study of some of them in 1973 examined the influence of the physical and psychosocial environment on their decision making processes

especially in relation to fertility planning. From that study I found evidence that the environment did play a major role in their problems of dislocation and disorganisation.

Impaired self-image or feelings of low self-worth can be a big impediment to effective social functioning. The relevance of wanting to motivate higher aspirations finds its ground in what some of them had to say about themselves and their situation when we first met. The gist of what was generally communicated was, "we are ashamed of the place we live in. Our home and neighbours are not what we would welcome others to. We could be badly beaten or our children molested, the police will not raise an eye - for this is what is expected of us and of our quarters."

I found then, in talking with these families in our native tongue, Tamil, that not only I, as a social worker, found their lives disorganised and unsatisfactory, but the majority of my respondent families felt likewise and said so.

Because of the nature of their inadequacies, in family functioning, lack of foresight and planning for the future and problemmatical family relationships, I questioned whether a shiny new flat, more space and a clean corridor, although it might be seen as a new lease of life, would automatically resolve these families other problems relating to finance, the burden of large families and the low achievement levels of these children, to name a few. These are people who have lived and bred a second and third generation in a very inadequate social environment. Living patterns used to be dictated by a room, communal kitchen and toilet. Re-housing brings with it a potential for a more organised and self-contained life. Because of improved facilities, such as kitchens and bathrooms, they no longer need to wait their turn to cook, children need not be fed in a hurry, or bathed in a hurry - or sometimes not at all - before being packed off to school. But the question remains, will the mother now be able to organise her life differently so as to have more control over her time and decisions or will old habits die hard? Will this changed and

improved home environment enable the spouses now to think of contraception, for instance? Will it improve the quality of their communication and hence decision-making capacities? In my opinion it would be naive to make such an assumption, given the past history and social conditions, and past and present lifestyle of these families.

I believe that changes are required not only in the physical environment but in the whole range of family functioning skills. Matters such as children leaving school prematurely, delinquency, chronic bad budgeting, low nutritional levels and uncontrolled family size are all areas where change must be effected. These observations are based upon my previous experience with clients of similar circumstances and backgrounds. Impressionistic though they may be, I cannot on the other hand disregard symptoms of disorganisation and dissatisfaction that "practice sensitivity" picks up from these families, and thus these observations form the basis of the hypotheses behind this study.

Intuition and "practice sensitivity" may not constitute "hard" data but are nevertheless essential in the practice of social work. Blenker speaks of an "intuitive mind"[2] as one of the most important characteristics of the caseworker and Specht in his paper "Theory as a Guide to Practice"[3] argues at some length the validity of "practice wisdom" which is a combination of imagination and intuition. He maintains that most theories employed by practitioners are not explicit and do not comply with the scientific requirements for "acceptable theory" and concludes that professional practice will always rely on this "inarticulated theory". He argues that the professional social worker works with a mixture of well articulated theory and "practice wisdom". My assertion, or hypothesis, in this case, is based on previous experience with a similar client group and "practice wisdom" that has not been scientifically systematised or tested.

In formulating a hypothesis, non-tested observations need not necessarily be rejected on the grounds of subjectivity. In my view, a distinction can be made between instinctive versus trained, or lay versus professional sensitivity, observation,

intuition or "feel". Armed with these, one can formulate a theory and set to work on it.

On this basis and accepting my assumption that rehousing alone is insufficient to enable families to raise their social functioning levels the next big question is whether, in addition to rehousing, social work intervention can influence family functioning levels to the extent that clients achieve some satisfactions that they currently claim they do not have.

Before proceeding to deal with this question in specific terms, I must hasten to add here that this query does not challenge the worth of social work as an enabling process. It has been recognised that social work brings about change in social adjustment, symptom relief, increased self-awareness and even perhaps personality reorganisation. The Family Life Improvement Project[4], however, challenged the notion that social work skills were most effective in improving inter-personal relationships. It was found amongst the families studied that changes were brought about in instrumental functioning such as child rearing, health practices and home management, but work with inter-personal relationships had shown little success.

Whether this means that social work is ineffective in this sphere is debatable, for the biggest obstacle in solving such a problem lies in defining success. As Plowman[5] points out "the very term success in casework is both vague and loaded with values - values which are all too often not made clear". The effectiveness of any form of social work can only be measured in terms of its objectives. Objectives or "the desirable" more often than not will involve values and value-judgments. Despite this, goals have to be formulated and social work must be directed towards achieving these goals. Thus the specific question must then become, what form of social work will be most appropriate and beneficial for meeting the particular needs of specific client groups?

The Questions Refined

Having hypothesised that social work is necessary the question is what type of social work should it be? My own observations over a period of four years have indicated to me that the conventional social work approach as practised in Singapore with this client group did not greatly effect change. In my experience in working with juvenile delinquents and adult probationers from some of these families, I observed that many who received traditional social work over prolonged periods of one to three years at the end of that period demonstrated no significant change in social functioning. I feel, therefore, that more than 'conventional' casework is required with these sub-cultural families and that the help offered should not be drawn out. I felt that to make any impact, a multi-level approach within a short treatment period, with the focus on immediate and achievable goals, might be a better approach.

Several studies support my personal observations and rationale and show that short term, task-centred intervention is not necessarily inadequate, and indeed may be better. These studies will be discussed later.

It is inevitable that amongst a total client population there will be varying degrees and levels of competence in family functioning and family management. That is, the "base-line" of functioning capacity may be very different. Therefore the level of family functioning must be assessed prior to intervention. It may be that families with a slightly higher initial level of functioning may need less actual social work, but this may not necessarily be the case, and indeed it may be a false assumption to make. On the other hand, families of a higher level of functioning but with specific problems may not need to go through the whole treatment process. Intervention may not need frequent contacts and could be less directive and more advisory. It may not need the active physical participation of the change agent and the action system could use more logical discussion to activate task achievements.

Often in practice as I have experienced it to be, social workers assess the coping capacities of their clients and not too consciously decide on the intensity of intervention. If it was found that a less intensive approach would suffice a particular client, then this decision should be deliberate and be accepted and used as a matter of practice. Thus, maintaining clients in two different categories of intensity of treatment will surely allow a worker to use time and expertise more economically which should help the process of wider and more positive coverage of professional assistance given.

Developing the Brief Task-Centred Unitary Approach

The purpose of the following discussion is to show why one particular model of social work intervention was chosen as against other types of intervention or practice modalities and I shall attempt to outline the development of the brief task-centred unitary approach, used by myself in this study.

Nothing is more relevant in this context than Goldberg's postulation of the need for "a necessary shift from social workers' eternal preoccupations with process to a consideration of outcome and specific changes aimed at."[6] As stated earlier, I had come to the conclusion that the conventional casework approach with long term goals had very little or no effect on these particular clients. I felt that social work with this group must be very sharp and focused and the treatment period must be short. Such task-oriented, short term intervention should concentrate on a limited number of achievable goals and more attention should be paid to the client's conception of his problem and possible solutions.

As pointed out earlier there is evidence to support a shift from conventional social work to a more short term, focused developmental approach. Reid and Shyne's experiment[7] found, for example, that families receiving time-limited but more intensive service progressed faster and further than those receiving on the whole quantatively more service but over a much longer period of

time. Follow-up data shows that changes effected by planned short-term service were as durable as those gained by open-ended service.[8] Even their conservative interpretation of the findings noted that open-ended service was no more effective than planned short-term service. Reid and Shyne's model will be further discussed in a subsequent section.

Subsequent to Reid and Shyne's original work, several other experiments have tested planned short-term service and Reid and Shyne chose three for comparative analysis. The study by Avnet[9] in short-term psychotherapy concluded that planned short-term service met the dire needs of a great number of patients and it was for many the only alternative to no treatment at all. It further managed to draw into treatment those who shunned treatment believing it to involve intensive and extensive analysis. Shaw's study[10] of families who sought help for child-related problems suggests that "with proper case selection, short term treatment is a highly efficacious type of intervention which produces desirable benefits." Finally, Gottshalk[11] reported after a study of brief psychotherapy that such treatment "was found to be associated with symptomatic and functional improvement among a high percentage of psychiatric patients, a change in psychiatric status that was maintained at least for several months."

All these research findings provided sufficient impetus for me to decide that treatment in this experiment should be brief.

Complementary to the brief treatment model is the Task-Centred Casework Scheme.[12] This model encompasses a wide range of specific problems which are the target for action. Here target problems must be those that the clients are both willing and able to work on either independently or through their agents, i.e., the social workers. The problems must be limited to specific behaviour or circumstances.

Several experiments based on the Task Centred Scheme model have been carried out, and seven experiments in Task Centred Casework with families were reported in a compilation by Reid and Epstein.[13] An overview of three of these experiments is reported here.

In Reid's study[14] which focused on marital relationship, 74% of the cases showed at least slight alleviation of problems. Of this 74%, 48% improved considerably. The remaining 23% showed no change and 3% worsened. Wise,[15] experimenting with 10 cases of marital discord in his 'Conjoint Marital Treatment' experiment, concluded that: the clients' self esteem improved and they began acting towards accomplishing tasks that they set for themselves. In the third reported experiment, a state level experiment in foster-care, Salmon[16] considered that "nothing has occurred to discourage the agency in its continued use, and furthermore, TC had proved useful in direct work with adolescents in foster-care".

I therefore felt it appropriate to base part of my social work intervention upon the concept of brief and task-centred casework. I felt, however, that casework alone would be insufficient to help these families. The kinds of problems faced by my clients in this particular sub-culture would, I felt, almost certainly need action and active intervention in other systems in addition to the client system. Hence my attempt to develop a multi-level action model incorporating the brief, task-centred approach but within a wider developmental framework.

Families have to cope not only with inter-personal relationships but have to manage intra-personal contacts with systems outside the family. Specht[17] rightly observes that casework uses an almost entirely psychologically-based body of theory, attending mostly to the individual's inner needs and life and inter-personal exchanges and paying little attention to other variables. Admittedly another important social work function is to link people effectively with systems that provide resources, services and opportunities to enhance their problem-solving and coping capacities. Seebohm's[18] implication that social service must enable individuals to deal with their environment is thus valid here. At least five field experiments[19] have shown that families classified as "multi-problem" gained more from the multi-level approach combining environmental help and emotional help than from casework intervention alone, and that multi-level intervention had a greater impact on social functioning and reduced practical needs more than single service projects.

The client population of this study, as described before, has had a history of isolation and little experience in interacting with or tapping resource systems. The only resource for these people has been the informal or natural resource systems which consist of family, friends, neighbours and co-workers. Relying again on my previous knowledge, it was evident that little use was made of formal resource systems such as labour unions, co-operatives or community associations or of societal systems like hospitals, schools, housing authorities, police or material aid agencies. Several factors may hamper the effective utilisation of the systems, the most obvious being lack of knowledge or hesitancy to use them, a resource system not being available or the policies of these systems not being sympathetic to this client group.

Accepting that social workers must be enablers or co-ordinators of communication between the client system and the target system, the action system then must allow for whatever approaches are necessary to activate task achievements. The Unitary Approach which embraces this consideration perceives the client as being not only within the counselling walls but within the interactional sphere of the multiple components of the social system. If the client is not an entity but a fragment of the whole system, surely a fragmented social work approach will not enable efficient functioning.

When the characteristics of the client population, to be described in more detail later, are studied, it will be evident that most, if not all of them can be classified as "multi problem" families. Thus my decision to apply a unitary model of intervention. A model that sets the unitary approach in practicable terms is the Model for Social Work Practice formulated and described by Pincus and Minahan.[20] This model avoids conceptualising social work practice in such dichotomous terms as personal versus environmental, clinical practice versus social action and micro system versus macrosystem. Although I will deal with this model in more detail later, briefly the theory is that professional strength is in the recognition of and working with the interrelationships between these elements.

In conclusion, I felt that the kind of approach that would most benefit my particular kind of client group would be one that incorporates elements from the two selected models of social work intervention, namely, the brief, task-focused approach of planned short term treatment and the multi system, unitary approach of Pincus and Minahan.

The Need For An Experimental Design

The nature of the research problem and type of research questions asked dictates the research design. In this case my research questions were directed as follows:

1. Will this client group improve its social functioning through rehousing alone?
2. If not, will social work intervention help?
3. Of so, what type of social work intervention will benefit what sort of families facing what kinds of problems and
4. How intensive does the intervention need to be to effect change?

In order to answer these questions, strictly speaking, the study should utilise an experimental design. Furthermore, the experimental model must be rigorous in the allocation of clients into a control group and treatment groups and should attempt to prevent contamination and the Hawthorne effect. Given the nature of the client population, their recent environmental changes and the potential influence of such upon them, together with the great possibility of contamination from other social agencies, it was only practicable and feasible to conduct this study on the basis of a quasi-experimental design. Although this design permits some factors to go uncontrolled, it nevertheless has its basis on prior recognition of variables which are controlled and those which are not. Possible misinterpretation of results is recognised and conclusions are then made with this in mind.

The Conceptual Framework And Problems Of Measurement

The fundamental question is whether family functioning improves with social work intervention. Before any attempt is made at effecting and measuring change it is necessary that the concept of family functioning is well defined. The constitution of family functioning or the variables which affect or effect functioning have to be clearly set out. Theoretical concepts of behaviour have, in turn, to be translated into observable and measurable terms.

Secondly, a measurement tool is required to establish whether families improve or not with intervention and if so to what extent. In other words, to rate families' functioning levels and to find out if the intensity of intervention has influenced outcome and if so, on what particular dimensions.

Quantum and Control

To validate the assumption that families' functioning initially at different levels may need different intensities of intervention, input must be quantified. Differentiating "moderate" treatment from "intensive" treatment means placing various limits in areas of problems worked, contacts made and emotional support given.

It also entails setting priorities to problems and choosing areas that would effect most change.

To meet the requirements of the central issue of whether rehousing alone will effect changes in family functioning and life-style, a control group is necessary, a group which must receive no social work.

Summary

The central issue posed in this study is whether environmental change per se for the client group can affect their social functioning sufficiently to bring about a more satisfactory way of life. If it does not, then the question is can social

work introduced at this stage of transition help improve their social functioning levels?

My past experience with this client group had shown that conventional long term casework had little effect on them and thus my aim in this study is to test if short and focused treatment might prove more beneficial. As this client group was known to possess the characteristics of "multi-problem" families, I decided that casework intervention alone will not be of much use - a multi-level treatment model might be a more suitable approach to take with this group. This led to the need for developing a specific social work model for treating this group.

Reality is that people and or families function at different levels. Thus intensity of treatment should be based on their coping capacities. Furthermore if it is found that treatment need not be uniformly intensive for all then a relatively less intensive treatment approach can be consciously and deliberately prescribed for appropriate clients.

In order to answer the questions raised in this study:

i) family functioning must be defined and measured,

ii) one control and two experimental groups must exist and,

iii) intensive treatment must be differentiated from less intensive treatment.

References

1. P. Gopinathan, 1974.
2. M. Blenker, "Obstacles to Evaluative Research in Casework" Social Casework, Vol. 31 March (1950) pp. 54-97.
3. H. Spect, Theory as a Guide to Practice in Integrating Social Work Methods ed. Spect and Vickery (London 1977) pp. 29-30.
4. L.L. Geismar, "Implication of a Family Life Improvement Project" Social Casework, 52, July (1971) pp. 155-165.
5. D.E.G. Plowman, What Are The Outcomes of Casework? (1967)
6. E.M. Goldberg, Evaluating The Success of Social Work (Assn. of Directors of Social Services Study Conference (1972)).
7. W.J. Reid and A.W. Shyne, Brief and Extended Casework (New York, 1969) p. 97.
8. Ibid, 1969, p. 175.
9. H.H. Avent, "How Effective Is Short Term Therapy" in Short Term Psychotheraphy ed. L.R. Wolberg (New York 1965) pp. 7-22.
10. R. Shaw, "A Short Term Treatment Programme and Its Relevance to Community Mental Health", et al p. 20.
11. A. Gottshalk, "Prediction and Evaluation of Outcome in an Emergency Brief Psychotherapy Clinic" in The Journal of Nervous and Mental Disease, Vol. 144, February (1977) p. 95.
12. W.J. Reid and L. Epstein, Task Centred Casework (New York 1972).
13. W.J. Reid and L. Epstein, Task Centred Practice (Columbia 1977).
14. W.J. Reid, "Process and Outcome in the Treatment of Family Problems", et al, p. 58.
15. F. Wise, "Conjoint Marital Treatment", et al p. 87.
16. W. Salmon, "A Service Program in a State Public Welfare Agency", et al pp. 121-122.

17. H. Spect, 1977, p. 31.

18. Report of the Committee on Local Authority and Allied Personal Social Services Series (London, 1972).

19. E.M. Goldberg, 1972.

20. A. Pincus and A. Minahan, Social Work Practice: Model & Method (New York 1973).

CHAPTER IV

THE STUDY DESIGN

A study such as this requires that family functioning be defined before attempting to effect change. What constitutes family functioning and the standards of its adequacy and inadequacy have to be established.

My conceptual framework for studying family functioning is based on the hypothesis that, for a family to function adequately in a modern, urban and industrial society such as Singapore, its value system must generally be modern as opposed to fatalistic. The family must have definite views on achievements and aspirations. It must possess sufficient information to facilitate decisions being converted into actions, with the family structure being efficient and flexible in coping or managing social functioning.

This experiment required me to place families at different levels of functioning and for this purpose a rating scale was necessary. The scale has to measure specific areas of functioning in the family and also provide a composite outcome score. It could not be at variance with the conceptual framework that defines family functioning.

A Conceptual Framework For Studying Family Functioning

In order to construct a framework for this study two models were heavily drawn upon. As neither was suitable in its original form for this particular study, adaptations were made from both to construct a specific model for this study. Thus the model used in this experiment to study family functioning is essentially mine.

The first scheme considered, that of Hill, Stycos and Back,[1] was originally used to study the factors that influenced fertility behaviour. Their assumption was that as fertility was an issue that was decided upon and executed at a family level, it was

greatly dependent on interactions within the family and the family's interaction with systems outside itself. Thus, breakdowns in role playing, communication, conflicts, compromise and consensus, which are elements of interaction, will affect the interactional pattern thus jeopardising the decision making and action process in fertility planning.

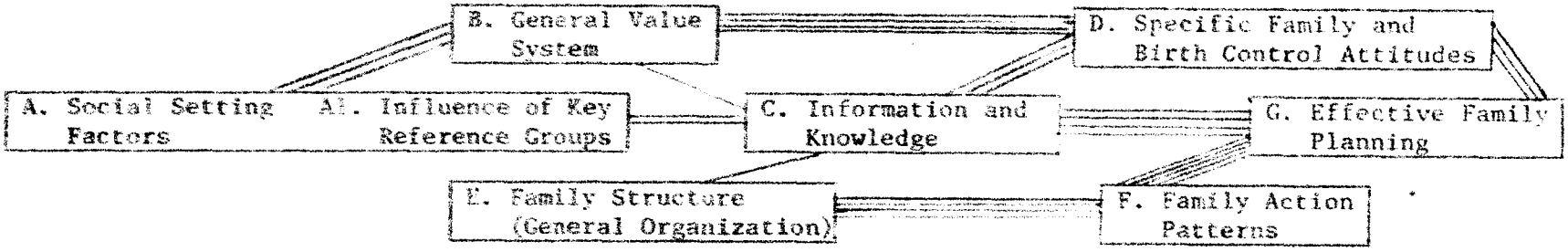
Hill's schema conceptualises family functioning in terms of seven blocks of variables. The blocks relate to:

(A) Social Setting Factors,
(A1) Influence of Key Reference Groups,
(B) General Value Systems,
(C) Information and Knowledge of Contraception
(D) Specific Family and Birth Control Attitudes,
(E) Family Structure,
(F) Family Action Pattern and
(G) Effective Family Planning.

The first block consists of a set of independent variables which, with the intervention of the other five blocks will result in effective family planning (see figure 1 for detailed schema outline). Their conclusion was that in order to make a decision on family planning and family size and to structure behaviour towards achieving this goal certain pre-conditions, influenced by certain other factors, must exist.

An issue in this study is whether rehousing alone will influence better social functioning and if not what else must be done and where action should be aimed to achieve this goal. The framework evolved by Hill et al sets out the different factors that affect functioning, housing being one of the variables of the social setting factors. Furthermore one of the implications of their study was that conditions which promote effective planning of family size might be similar to those that facilitate effective family functioning in many other areas.

Figure 1. Schema Specifying the Hypothetical Interrelationships of Selected Antecedent, Intervening, and Consequent Variables in Fertility



A. Social Setting Factors

- Residence
- Occupation
- Education
- Religion
- Economic status
- Marital union
- Age at marriage

A1. Influence of Key Reference Groups

- Neighbors
- Work mates
- Classmates
- Fellow parishioners
- Fellow sufferers
- Married set
- Marital cohort

B. General Value System

- Fatalism-striving
- Traditionalism modernism
- Aspirations for self and children
- Tendencies toward general planning

C. Information and Knowledge

- Extent of knowledge about birth methods
- Timing of learning about methods

D. Specific Family and Birth Control Attitudes

- Importance of children
- Ideal family size (present and past)
- Summary index of family size preferences
- Interest in spacing children
- Attitudes about birth control methods
- Saliency of family size as a problem

E. Family Structure

(General Family Organization)

- Extended vs. Nuclear family household
- Power Structure
- Role allocation structure
- Affectional structure
- Familistic Organization
- Degree of wife's mobility
- Degree of male dominance
- Prohibitions exercised by husband

F. Family Action Patterns

- Marital communication on general issues
- Communication on family-size ideals and birth control
- Marital empathy
- Modesty and respect handicaps
- Marital consensus
- Marital happiness
- Sexual satisfaction
- Family readiness for action on birth control

G. Effective Family Planning

- Ever use of birth control methods
- Length and regularity of use
- Success rate (proportion of unplanned pregnancy per woman month's exposure)

Before discussing the reasons why Hill's model was not used in toto but only drawn upon with incorporations from another model, let us consider the model devised by Geismar and Ayres.[2] The theoretical basis of this model is that each member of the family plays a specific role in order to fulfil basic social functions and a failure on the part of any family member to play the role expected of him will have its repercussions in the overall functioning of the family.

The second scheme considered, that of Geismar and Ayres, conceptualises social functioning in nine categories. Seven of these relate to the way in which basic tasks necessary for a family's unity and welfare are performed. The nine categories being:

(a) family relationships and family unity,

(b) care and training of children,

(c) health problems and practices,

(d) household practices,

(e) economic practices,

(f) use of community resources and

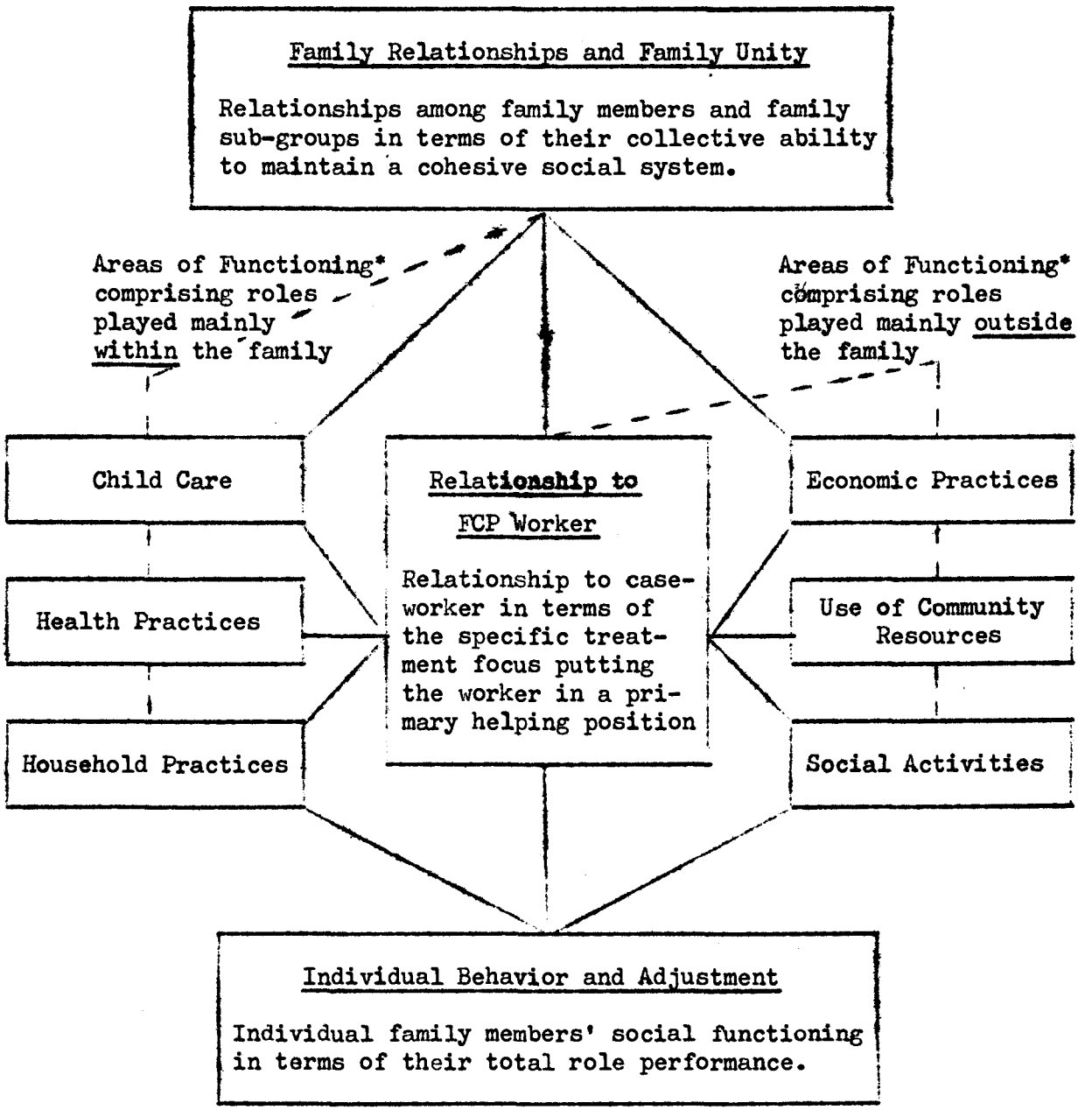
(g) social activities,

(h) individual behaviour and adjustment, (constitutes an evaluation of the family members' performance and their social roles or, to relate to this study, their social functioning.)

(i) the family's relationship with the social worker as a helping agent.

These categories are divided into two groups; one comprising the area of functioning necessitating role performance basically within the family and the other of role performance outside the family. (See figure 2 for a diagrammatic representation of this model).

FIGURE 2. Categories of Social Functioning



* The areas represent a convergence of family members' roles in culturally defined areas of social functioning.

The theory behind this model is that the interdependence of these two levels of functioning leads to complete social functioning and that social roles cannot be categorically stated to be in one group or the other. For example, roles in the economic practices area have to be performed both within and outside the family. Economic functioning requires the holding of a permanent job and the securing of an adequate income and it also demands realistic management of money within the home. Thus the evaluation of functioning in one area has to take into consideration the roles played in both areas.

Reasons For Not Using Either Model Without Adaptation

There were three main reasons for not adopting Hill's framework without adaption. First, the schema developed by Hill, Stycos and Back is geared towards studying and evaluating fertility behaviour, thus the emphasis is on family planning rather than social functioning as a whole. Three of the seven blocks of variables in this framework concentrate on eliciting data on fertility; a concentration that is not necessary for this study.

Second, the scope for gathering data on economic, health and household practices, for example, is limited in Hill's framework, and their questionnaire based on their schema is tailored to meet the norms and practices of their specific client group. Given the nature of this study's client group and the nuances of Singaporean-Indian culture, many items would have had to be omitted or changed.

Third, Hill's questionnaire is not open ended and provides for only specific responses. I felt that I needed a more personal method of data collection, namely an interview schedule. Thus for the purpose of establishing a conceptual framework I found Hill's model very useful but as a practicable social work research tool it was somewhat inadequate.

As regards Geismar and Ayres' model, the main use to which the framework for studying family functioning was put was to provide a casework service to families with children in immediate danger. In my study, however, the family as a whole is the target for intervention. Thus confining myself to Geismar's framework would have meant overlooking areas of wider concern to the family as a whole.

Geismar's framework, moreover, does not, in my opinion, give full consideration to the influences of the physical environment, education or money. It concentrates primarily on the behavioural aspect of the family. Neither does it consider the influence of value systems. Both these aspects are very pertinent to this study.

Geismar's model contains nine evaluative categories. I have used eight of them, omitting the one which measures the client's response to the worker.

Thus, after close consideration of these two models, it became apparent that neither alone could be used without modification. Nevertheless, both contained useful and relevant aspects that could be drawn upon. What I needed to do in order to construct a framework specifically for this study was to modify the flow of cause and effect factors of these models, omit sets of variables that were not relevant and include measurable items that were particular to the culture of the present client group. In so doing I arrived at a framework that I considered to be specifically tailored to the client population in this study.

The Theoretical Framework Developed For This Study

The reasons for drawing upon the two models but not using either in toto have already been discussed. Perhaps it is necessary to elaborate further, however, upon the reasons for selecting certain clusters of variables and not others from within these models.

The categories used by Geismar and Ayres were devised specifically to study the functioning of seriously disorganised or multi-problem families and thus are of direct relevance to this study. In addition, Geismar has constructed a seven point scale on which functioning can be measured. The criteria for the scale positions are clearly defined and are identified closely with the categories, thus minimising anomalies between definitions of functioning and the measurement itself.

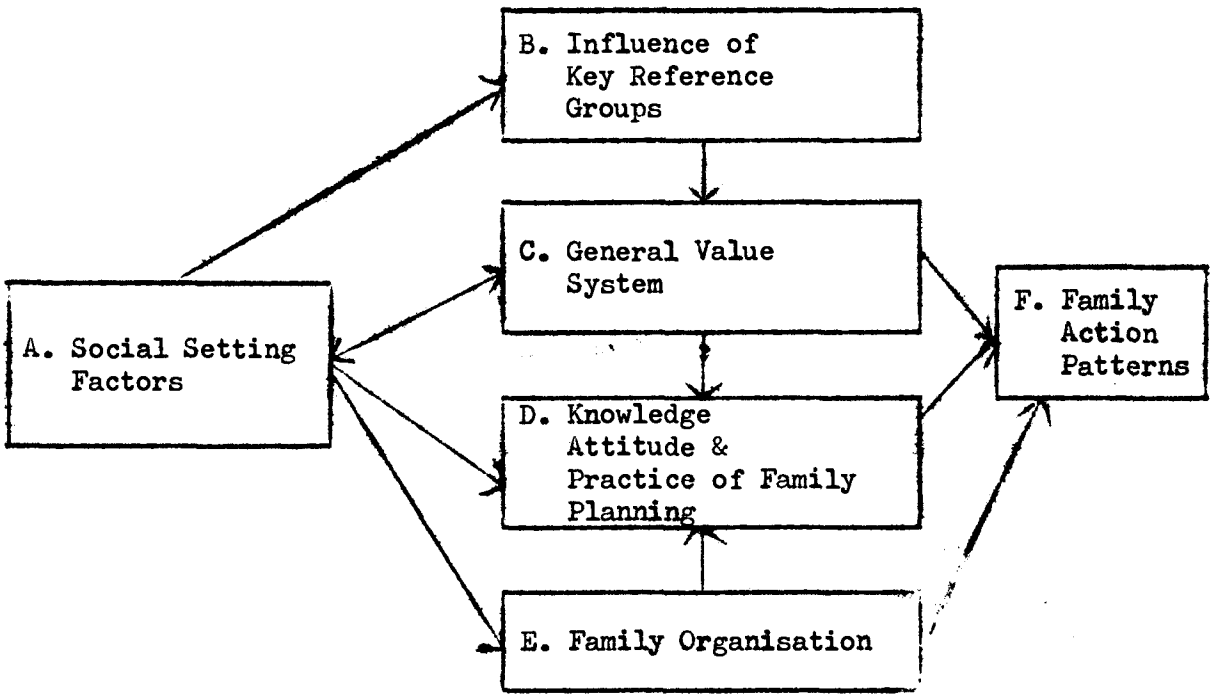
Incorporated into the schema outlined by Hill, these categories add more directly observable variables of family functioning. The necessity for obtaining as complete a picture of family functioning as possible needs no further elaboration.

Marrying these schemata is not paralogistic as the theoretical bases of both are complementary insofar as both recognise the importance of the interactional theory or, in other words, the importance of the interaction of roles or communication in the family, to family functioning.

Before producing the framework for this study diagramatically, it is necessary to show the modified version of both schemata that I have drawn upon. The following Figure 3 is the modified schema of Hill, Stycos and Back.

In comparing this diagram with that of the original it can be seen that the modified version consists of six blocks of analysis as compared with the original seven. "Social setting factors" have been separated from the "Influence of key reference groups" as it was considered that Block A should consist only of independent variables as the "Influence of reference groups" was not necessarily an independent variable for, with my client population, I felt that they could choose and thus could control the influence of reference groups. Block D consists of variables relating to knowledge of contraception and effective family planning - the change being that the original three separate blocks have been condensed into one.

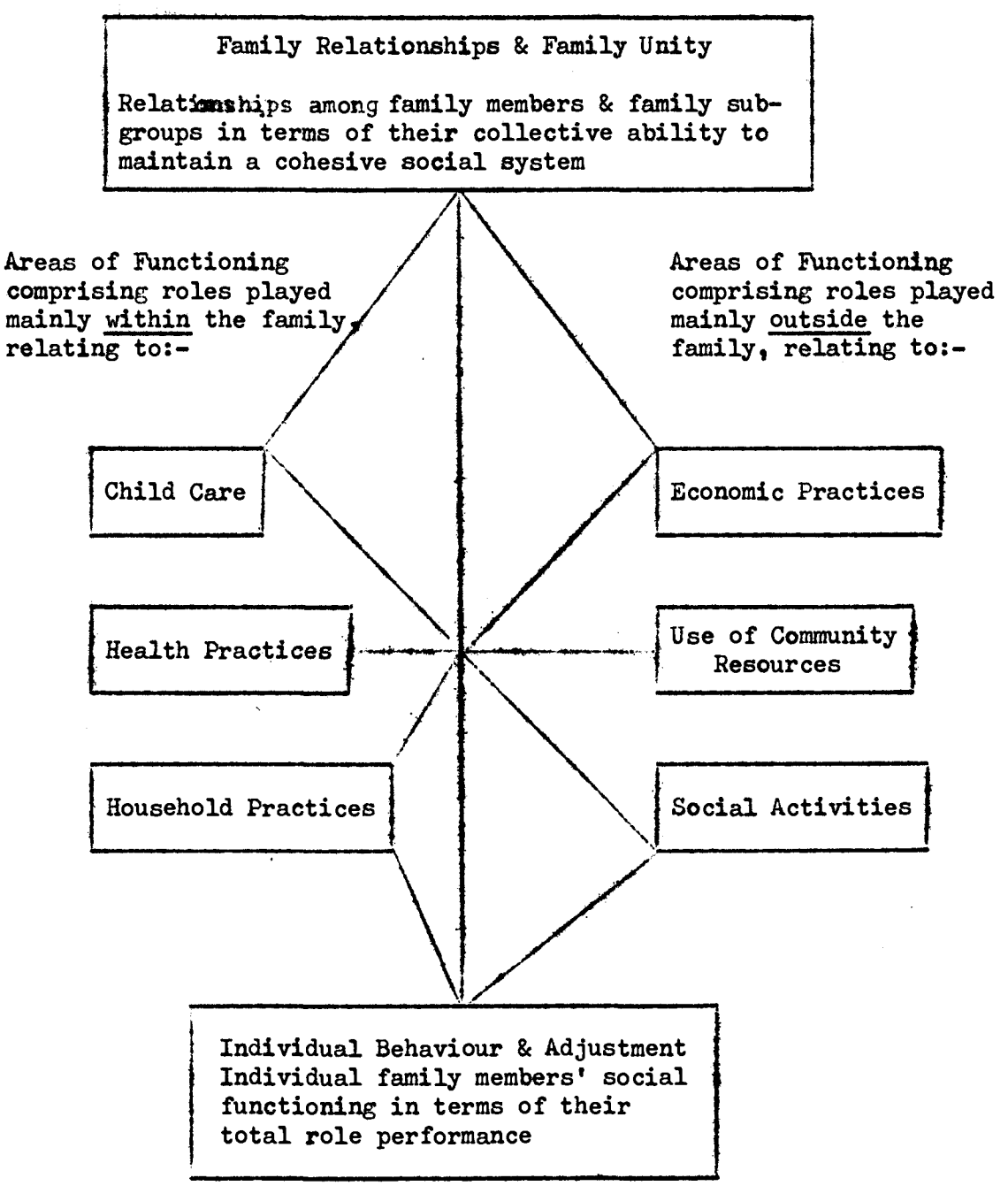
FIGURE 3. Schema specifying the hypothetical interrelationship of antecedent, intervening and consequent variables in family organisation (modified from Hill, Stycos & Back)



Finally, Block A as in the original has been placed as the independent variable. Blocks B, C, D and E are the intervening variables leading to the dependent variable Block F - the "Family Action Pattern". The adaptation here is to show "Family Action Pattern" as the resultant factor instead of "Effective Family Planning" as in the original.

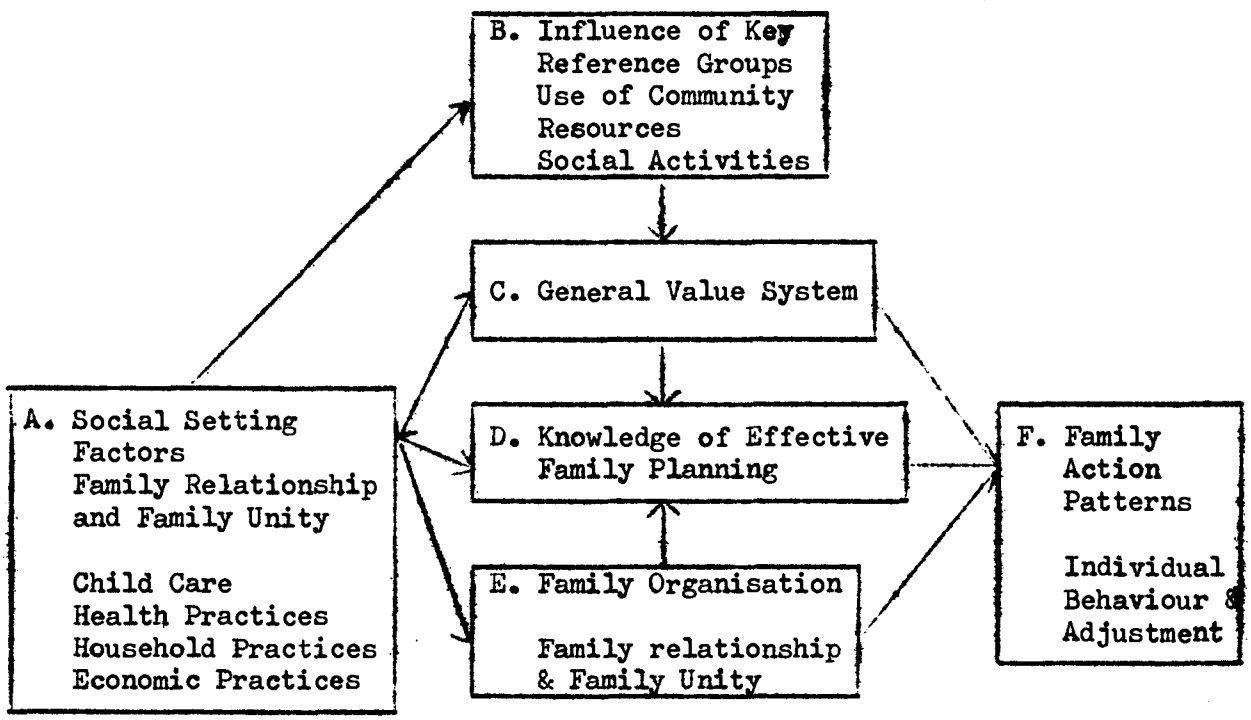
Figure 4 that follows shows the modified model of Geismar and Ayres. The only modification is the omission of the ninth category, "relationship to social worker", the reasons for which have been discussed previously.

FIGURE 4. Modified Model of Geismar & Ayres



To reiterate, the theoretical framework for this study draws heavily upon two sources, namely, the family functioning models of Hill, Stycos and Back, and Geismar and Ayres respectively Nevertheless, the final framework for studying family organisation as evolved by myself for the purposes of this study is essentially my own and is outline in diagramatic form below.

FIGURE 5. Schema indicating the hypothetical inter-relationship of variables in Family Functioning



As seen in figure 5, all eight categories drawn from Gesimar are incorporated into the six analysis blocks. The eight categories, as mentioned earlier, add to the variables that can be observed and measured within the analysis blocks. The specification of the variables and measurement within the blocks will follow the description of the analysis blocks.

Block A consists of the independent variables and Block F consists of the dependent variables. Blocks B, C, D and E are the intervening factors that relate A to F. In terms of data collection Block A consists of data on the composition of the family; its economic structure and practices; health practices; household practices; child care and the individual behaviour of the children. The hypothesis in the scheme is that possessing certain social setting factors, the family is amenable to the intervening influence and support of key reference groups that will affect its action patterns.

Another group of intervening variables consist of those in Block C. This Block conceptualises the family's general orientation towards change. It analyses whether the family adheres to traditional as opposed to progressive ways in coping with social functions. It further examines whether or not planning is valued or if fate is believed to be the determinant of quality of life. The family's aspirational level and actions taken to achieve this would all indicate the family's motivation towards change.

Block D is closely related to Blocks B and C in that it reflects values and motivations. This Block includes data on spouses' attitudes towards fertility control and planning; the importance placed on children; the number of children considered as ideal; the technical knowledge possessed to practise contraception and action taken which will all indicate if the family is actively moving towards achieving its goal. The interrelationship of Blocks B and C with this Block will influence the measures of its variables.

Block E refers to the patterns of allocation of power, responsibility and task performance and includes affectional ties in the family. This Block examines whether the family structure is restrictive in limiting the wife or children in their mobility to participate in or activate their social roles outside the family. This Block summarises the family structure with its values, motivation and knowledge to act towards change.

Finally Block F conceptualises the action potential of the family as a whole. Although this Block specifically dwells on the marital system, it is nevertheless considered to be the most important system that decides on and channels the resources to make action possible. This Block is the consequence of the family structure which is arrived at through the process of the intervening variables.

Block F measures the extent to which the family, with its particular structure, can or cannot implement joint and/or individual goals; whether there is consensus on most matters or whether there are barriers to communication on marital, familial and fertility issues; whether there is any initiative taken by one or other spouse or both in the crucial area of family functioning.

Responses to all of these types of questions indicate the degree of communication between spouses which will greatly influence the family's action pattern.

The Measurement Scale

For the purposes of my experiment it is necessary to rate families' levels of functioning at different points in time for two reasons; first, so that the outcome of treatment can be measured against a pre-treatment base-line; and second, to answer the question of whether families at different levels of functioning initially need varying intensities of social work intervention. The scale has to measure specific areas of functioning in the family and has also to provide a composite score. The scale cannot, obviously, be at variance with the conceptual framework that defines family functioning, hence my adaptation of the seven point scale used by Geismar and Ayres, as their definition of family functioning and measures are part of the conceptual framework for this study.

A Diagramatic Representation of the Model Adopted

Block A - Social Setting Factors	
Variables	**Measured in terms of**
Socio-economic Status	Education of wife Education of husband Occupation of wife Occupation of husband
Residence	Type of residence Rented or ownership
Age	Wife, husband
Martial History	Type of marriage Age at marriage Number of marriages Length of marriage.
Children	No. of children Ages of children Occupation of children
Individual Behaviour & Adjustment of Children	Delinquent behaviour Mental and physical health Mental retardation Physical disability
Individual Behaviour and Adjustment of Adults	Delinquent behaviour Mental and physical health Mental retardation Physical disability
Care of Children	Physical care
Economic Practices	Source and amount of income Job situation Use of money
Household Practices	Physical facilities Housekeeping standards Dietary patterns

Block B - Influence and Use of Key Reference Groups and Resources	
Variables	**Measures**
General Influence of the Community	Communication and agreement with friends, relatives and workmates
Use of Formal and Informal Associations	Relatives, friends, schools, religious bodies, medical facilities, social service agencies

Block C - General Value System	
Variables	**Measures**
Traditionalism & Planning	Work v. Luck Women going out to work Daughters being schooled
Aspirations	Satisfaction with life. Level of satisfaction with conditions over 5 years Should children follow in father's footsteps
Tendencies Towards General Planning	Planned Life v. Fate

Block D - Knowledge of and Effective Family Planning	
Variables	**Measures**
Importance of Children	Satisfaction with number of children
Ideal Size	Number of children desired as ideal
Knowledge of Contraception	Types known and how they work
Use of Contraception	If in practice
Attitude	Feelings about and for use or non-use of contraception
Modesty	Communication with related professionals

Block E - Family Organisation	
Variables	**Measures**
Parent/Child Relationship	Satisfaction with childrens's progress Conflicts with children Anxiety over children
Relationship between Children	Discord between children
Training Method and Emotional Care	Discipline Show of affection
Role Allocation Structure	Pattern of father, mother and children doing specific tasks. Consciously or unconsciously evolved
Mobility	Any specific prohibitions

Block F - Family Action Patterns	
Variables	Measures
Marital Happiness	Emotional tie between spouses. Extra marital relationship.
Individual Behaviour and Adjustment of Spouses	Delinquent behaviour, drinking, deficiency in social skills
Marital Consensus	Conflicts, decision making process, agreement.
Marital Communication	Communication on household, children & related matters
Modesty	Communication on sexual and contraceptive matters
Sexual Satisfaction	Contentment in sexual activity
Role Performance	As spouse, parent, breadwinner, home-maker, member of community

The classification of any set of behaviour patterns as adequate or inadequate has not often been specified in research by social workers although it is invariably done in practice. The basis for the formation of the scale by Geismar and Ayres is that:

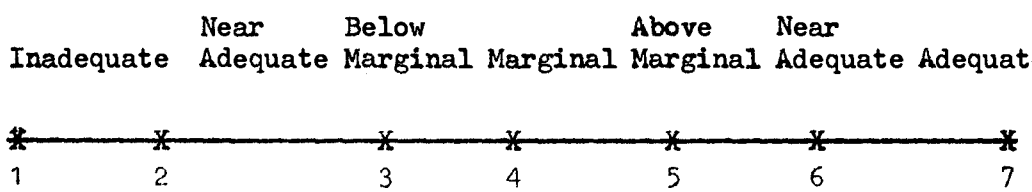
> "If casework can make a clear case regarding the need for treatment on the basis of a family or individual being a concern to the community then it ought to be possible to translate 'concern' into standards of family functioning which would represent minimum standards of performance barely above the level at which the community has a right to intervene."[3]

The community's right to intervene is easily defined on the basis of behaviour which clearly violates the law, but "behaviour to cause concern" would be based on the extent to which a family violates mores which are part of the basic value system. A scale consisting of a simple dichotomous distinction between "problem" and "no problem" allows no leeway for the community to translate concern into intervention nor for the family to seek aid. Situations where the well-being of the children is affected by deviant behaviour, their own or that of adults, would put a family on the lowest point of the scale and therefore justify intervention. But, situations in which children are, for instance, deprived of a full socialisation process, such as not being allowed to join peer groups, will not be considered quite so serious, and placed not at the bottom end of the scale but at a marginal level of social functioning. Hence this scale has three anchor points comprising "adequate", "marginal" and "inadequate" functioning, with functioning at each level being clearly defined. The four additional scale points are to allow for flexibility of ratings that fall between these three anchor points for, in reality, there would be families that function just below or above marginal levels and families that are not totally inadequate but are near inadequate.

The diagram below shows the seven point scale with functioning defined at the three anchor points.

FIGURE 6. A diagrammatic representation of the rating scale

Scale



Definitions of functioning at the three anchor points are made for all areas and are reproduced in appendix III. Functioning at the four additional points is not spelt out by the authors but is left to the discretion of judges. Although in the manual produced by Geismar, three independent judges scored the families' functioning levels, generally at least two judgments were considered acceptable for reliability. Thus in this experiment both the pre-test and the post-test scores were done by two judges: myself and an independent evaluator. Whenever there were differences of an opinion relating to positions or movements it was planned that consultation between the two judges would take place in order to arrive at a consensus.

FIGURE 7. General Criteria For Levels of Social Functioning

Inadequate	Marginal	Adequate
Laws and/or mores are clearly violated. Behaviour of family members constitutes a threat to the community.	No violation of major laws although behaviour of family members is contrary to what is accepted by the status group.	Laws are obeyed and mores observed. Behaviour is acceptable to the status group.

N.B. - These general criteria include more specific definitions as regards the welfare of children. However, for the present study, these have been excluded as the children are not - unlike the St. Paul's project - the main target group.

In order to divide the client population in this study into three groups, so that two different intensities of treatment could be offered plus a control group, families were first classified into low, middle and high functioning families. The figure below indicates the categorisation.

FIGURE 8. The Three Categories of Functioning

Inadequate	-	1	
Near Inadequate	-	2	LOW
Below Marginal	-	3	
Marginal	-	4	
			MIDDLE
Above Marginal	-	5	
Near Adequate	-	6	
			HIGH
Adequate	-	7	

The Treatment, and Control Groups

Initial rating divided the families into three groups thus enabling me to select randomly from each group so that families could be allocated into (1) the intensive treatment group, (2) the moderate treatment group and (3) the control group. The employment of a control group answers the first research question and it also indicates what type of families and problems respond to treatment. Furthermore it may throw light on those which may show movements that have no direct relationship to treatment.

Two small examples illustrate the usefulness of control groups. In the Cambridge Somerville study,[4] although the therapists concluded that two-thirds of the delinquent children had improved with treatment, there was no difference in court appearances between the experimental and the control groups.

Another example, in which a simple comparison of statistics was made, was concerned with a decline in enrolment in schools of social work.[5] Enrolment numbers, when compared with those

of other professional schools, showed that the decline was no more than that found in other schools. Thus the assumption that a decline was a reflection of a decreased interest in the social work profession per se was proved false.

The allocation of families into the three groups needed to be randomly done in order to avoid the possibility that all high functioning families might fall into, for example, the intensive treatment group or more low functioning families accidentally find themselves in the control group.

A Model for Intervention

When a social worker has prior knowledge of and can anticipate the types of problems and the general characteristics of a client population, treatment can be focused and be more specific to problems when it is based on a model. However, the reality seems to be that few social workers use any one model or approach without adaptation. Usually the approach is eclectic, with the worker adopting only the salient features of a selected model or models. This is the case with the model of intervention which I evolved for this study.

Two social work models were drawn upon in designing the mode of intervention for this study, namely, the Task Centred Casework Model described by Reid and Epstein and the Model for Social Work Practice evolved by Pincus and Minahan. Although both are relevant to the treatment approach required for this study, neither could be used as they stood to meet the clients' total needs.

The Task Centred Casework Model addresses itself to working with consenting clients on specific "problems of living" within a limited time span. This is congruent with the treatment approach hypothesised as most suitable for my client population.

As mentioned earlier, some among the client group who received long term casework have shown no significant change, thus indicating a need for an alternative approach. The limitation of this model in relation to this study is that it is basically a casework model. Whether working with individual clients or collaterals, the social work approach used is casework on a one to one basis. As the client population in this study is perceived as a group within a community; the need, I felt, was for intervention at this level as well as on an individual basis.

To compensate for this drawback in the Task Centred Casework model, the Model for Social Work Practice was used. The strength of this model is a recognition that various systems are involved in affecting change, and it advocates the use of a variety of social work methods in working with one problem or with one client system. This gives the sort of flexibility required in working with my client population.

The purpose of this discussion is not to dwell on detailed descriptions of these two models, but to bring to the reader's attention the elements relevant to this study and the reasons for not using either model in toto.

The Task Centred Casework model considers the client's goal as of primary importance, as indeed does the Social Work Practice model. However, the premises in the latter is that no one system may be involved in change efforts without consequential changes in other systems. Goals thus have to be congruent with those of other systems. This is an awareness that the clients in this study need and yet lack. One of the major problems for these people has been their isolation - lagging behind in the process of integration has created a gap between them and the wider community, and not being able to cope with the pace of life in the community at large has been one of this group's drawbacks. Thus goals formulated in isolation will not assist them greatly.

In terms of formulating goals, the Social Work Practice model allows the client to be seen as inter-relating with the whole social system. This constitutes an approach complementary to the framework used in studying family functioning.

The Task Centred Casework model dictates that the client must work at specific problems and targets. These in turn must be acceptable to the clients themselves. If none is immediately evident the model allows for a search for a problem. Working on specific problems is the aim of this study, but I felt that for my purposes the time specified for the exploratory phase in this model is too restrictive. In the Task Centred Casework model the pressure is on completing problem formulation in the initial interview. With my client group, where lack of awareness or apathy is the norm, problem seeking and goal formulation can be a long and difficult process in which one interview will achieve relatively little. The Social Work Practice model, however, provides for an initial relationship instead of an initial interview. Taking into consideration the difficulties in establishing mutual goals between worker and client and the target systems, it provides for a bargaining relationship. After searching for and negotiating goals, a collaborative relationship is established to start task achievement. This does not negate the importance of recognising the client's own goals and in this study recognising the client's own goals and in this study recognition will lend greatly to boosting self worth and self esteem and a sense of purpose, which are themselves goals of this study.

The elements which my model for this study will draw heavily from the Task Centred Casework model are as regards problem typology and duration of treatment. These two areas are not clearly spelt out in the Social Work Practice model. The Task Centred Casework model categorises specific target problems under the headings of[8]:-

1. Interpersonal conflict
2. Dissatisfaction in social relations
3. Problems with formal organisations
4. Difficulties in role performance
5. Problems of transition
6. Reactive emotional distress
7. Inadequate resources.

In addition to the above classifications any other problem can be included if the client perceives and accepts that he has a problem and if the problem is limited and specific. This typology allows for the inclusion of almost all problems that the client group may present and thus helps in working systematically with them.

Certain chronic social problems such as neuroses, character disorders, alcoholism and drug addiction are not included in these categories. Although all of these or most of them will most certainly be presenting problems in this study, the scope of this experiment does not allow for active intervention with problems such as these. In this context the Task Centred Casework model clearly defines the working areas for this study.

The other element of the model adopted here is the time specific intervention approach. The Task Centred Casework model stipulates that the treatment period be two to four months. Allowing for a longer exploratory phase and the possible general apathy of the client group towards mobilising themselves, it was considered necessary to stretch the treatment over six months. The model also considers interviews occurring at weekly intervals as sufficient, but it permits frequency to vary. Again, considering my client group's disposition I felt that it might be necessary to maintain more frequent contacts to prevent the pace from slackening.

What emerges from the foregoing discussion is that the model used for intervention in this study consists of selected elements of both the Task Centred Casework and Social Work Practice models with relevant modifications. The model for this study adheres to the basic principles of both models. First that intervention should be brief and aimed at specific problems. Second, as social work practice involves working with more than just the client system, change efforts can be directed at different systems and at varying levels. The following format sets out the framework for the approach taken in this study. Techniques employed in implementation will be discussed later.

Framework for Intervention

Client	The family
Intervention Approach	Task-centred
Duration	Brief - 6 months
Interview Frequency	Once or more per week
Problem Definitions	Seven categories as in Task Centred Casework model
Intervention Process	Casework, Groupwork, Community Work

Quantum

As another purpose of this study is to test intervention intensity and outcome, the amount of social work input will vary from client to client in this study.

The model evolved for this experiment basically caters for intensive intervention. The two levels of intervention required for this study will be called "intensive" and "less intensive" treatment. For the group treated with intensive intervention,

the model will be applied in the devised form. As for the group treated with less intensive intervention the general framework will still apply but with the worker being less involved in the process.

The quantum differs between these groups in three major areas. As in the model, the intensive intervention group would have at least one contact per week and more if necessary. However with the less intensive group, contacts will be fortnightly with more only if it would be unethical to withhold intervention. As for the control group, which receives no treatment, monthly contacts will be kept merely to update data.

The exploratory phase will be the same for both groups as in the model, and the same problem typology will be used. The difference will be that if in the intensive group X number of problems are indicated then as many as time permits will be worked on. In the "less intensive" group even if X number of problems are presented, priority will not be determined by time but by the urgency of the problems and their effects on functioning. Attempts will not be made to gear intervention to work on all problems as in the first group. As an illustration, let us say that family Z in the first group indicates there are three areas for intervention; all of these three areas will then receive attention. Whereas in the second group family Y may indicate six areas but only three are decided upon for action. Thus quantitively the second group will still receive less input.

Finally, the change agent or social worker participation in the task achieving process is differentiated. In the intensive group participation will be as active as possible. For example, if the physical condition of the home is too disorganised for comfortable and hygienic living, the worker will if necessary literally "get down on her knees" with the mother to clean it up and straighten it out. Similarly if a child has problems at school, the worker would expect to accompany the parent to consult the teacher. In the "less intensive" group the worker

will simply identify the problem and suggest that the clients act on it themselves. Another example in the less intensive treatment process is, say, when the client needs material assistance, the worker will identify the resource system, advise on procedures on gaining it but leave the client to put this task-achieving process into action.

Quantifying input does not affect the quality of work. Qualitatively, intervention in any degree should be the same. It is not possible to attach specific numbers, strict interview duration and investment when working with people and their problems. It is only possible to curtail intervention in terms of a general criteria, drawing an analogy that not all hungry people need to be given fish, but perhaps just shown how to fish.

Selecting the client population

What follows is the presentation of the actual process of the experiment and a statement of the content of the interview schedule used in data collection.

Two criteria were applied in selecting the client population, namely residence and ethnic group. To be included in the study clients must have lived in the "Jalan Besar Quarters" - a housing district where all the city cleansing department's workers are housed. These quarters consist of one room, communal kitchen and toilets just as in the "lines" where the indentured labourers lived. The other criteria was that all clients had to be Indians. No distinction was made as to the type of Indian as it was known that most, if not all, were Tamils. No other Indian sub-group like the Punjabis, or Bengalis were known to be amongst these people. A sprinkling of Keralans was present but they were included because they spoke Tamil and lived in culturally similar patterns due to their long association with the Tamils.

Groundwork

Before any contact could be made with the client group, information such as names and addresses had to be obtained. As the population who lived in the "Jalan Besar Quarters" were with the cleansing services, the personnel section of the Ministry of Environment was able to provide 80 names and identity card numbers of household heads.

Since all these people were housed in one particular estate, the area office of that estate was contacted to trace their exact addresses. The data collected from the area office contained the addresses, the type of flat, i.e. one, two or three-roomed flats, and whether they were purchased on instalments or rented.

In order to organise the initial contact phase, casual visits were made to the blocks of flats to familiarise myself with their layout. This time was also used to spread the word of my intended study. Considering the nature of the study, it was important that my identity and role were made clear to the people. Thus time and attention were spent on explaining the purpose and mode of this study and to gain their confidence. Recognition of "old faces" (former clients) and their recognition of me as a social worker were used in establishing rapport and in soliciting the acceptance of the "new faces".

Data Collection

The client population was interviewed twice - first at the start of the study and later after six months of initial interview and before intervention. At each stage of data collection an interview schedule was administered rather than a structured questionnaire. I knew that the literacy rate of my client population was low and prior knowledge of the client group indicated that the response rate would be very low if questionnaires were left with them to be filled with no face-to-face contact.

In addition, an interview schedule would allow flexibility to include differences between individual family settings. A schedule was constructed based on the conceptual framework outlined previously. The first part of the schedule elicited factual information while the second part focused on family management. The first section consisted of questions on:-

1. Personal particulars of household head and spouse.
2. Number of members in the household and their circumstances.
3. Dietary patterns.
4. Income and expenditure patterns.
5. Modern amenities present in and the physical condition of the home.

Although the above areas seem straight forward and factual enough, they are nevertheless not impersonal data. Questions eliciting this data, however, had to be contained in the first half of the schedule as the subsequent questions touched upon comparatively more personal areas. Thus the need to establish rapport with the respondents even before administration of the schedule. The second part of the interview schedule included questions relating to:-

1. The family's general value system.
2. Family action patterns.
3. The influence of key groups.
4. Knowledge and attitude for the practice of family planning.
5. Family organisation.

The Process of Data Collection

Twenty randomly selected families were interviewed in the pilot phase. This pre-test showed up inadequacies in the interview schedule, which was suitably modified. The finalised interview schedule was then administered to the whole client population with myself as the sole interviewer.

The household heads, their spouses and, whenever relevant and possible, their children, were interviewed. Interviews were mostly joint as time and privacy seldom permitted separate interviews.

To gather reliable data, if it was found necessary, separate individual interviews were held. The interview schedule included data collected both through interviews and through direct personal observation.

This was a most time consuming phase, for appointments were frequently broken when the woman, for instance, on the spur of the moment would decide to visit her neighbour. Interviews were sometimes almost impossible to conduct for want of privacy or even, in some cases, from lack of coherence on the part of drunken husbands. As such, there were times when households had to be visited several times before all the data could be collected.

After the families had been interviewed no contact was made with them for six months. The purpose of this was to ascertain whether they were in the process of any change by virtue of rehousing alone. After six months the whole client population was re-interviewed to observe impressionistically if there were any changes without intervention.

On updating the interview schedules, the data on each family were transcribed from the schedule onto a standard data format sheet. The format was used to group relevant information within each analysis block, and the families, based on these formats, were rated using the framework and

rating scales described earlier, to assess the level of family functioning. Following this pre-test rating families were randomly allocated into either of the two-treatment or the one-control group. Social work intervention then commenced.

When intervention ended, the data formats were again updated, recording changes and movements. On completion of this process field work was terminated.

Data Analysis

As stated earlier all data gained from the study population were transcribed into the data format sheets. These sheets were used by both the independent judge and me to rate the families' functioning levels before social work intervention. The same data sheets updated after intervention were used to rate families' functioning levels after social work input.

To find out if social work had any effects at all on functioning levels the movements of both the treatment groups were compared with those of the control group. This analysis was to show the overall outcome of social work input.

In order to find out what type of families responded to what intensity of intervention, the variations of movement made by families of different levels of functioning within one treatment group were compared. This was to show what type of families responded more or less to that intensity of intervention.

Finally, the variations of movement made by individual families were compared between the two treatment groups to deduce which families functioning at a particular level responded most to a certain intensity of social work intervention.

The Response Rate

The initial number of names obtained was eighty. During the pilot phase, even before I could reach them, four families had moved to non-Housing and Development Board accommodation and eight were found to reside in two other estates, quite a distance from the one where the concentration was. To facilitate localisation of the study, these families were excluded, thus bringing the total sample size to sixty-eight families. During the six month period of "non-contact" with clients, another six families had moved to non-Housing and Development Board housing. The final sample then consisted of sixty-two families. Considering the causes for the reduction of the original sample size, which were out of my control, the response rate could be said to be 100%.

References

1. R. Hill, H. Stycos & K. Back, The Family and Population Control, (Chapel Hill, 1959).

2. L. L. Geismar & B. Ayres, Measuring Family Functioning (Minnesota, 1960).

4. Ibid, 1960 p. 15.

4. Powers, Edwin & Witmer, An Experiment In The Prevention of Delinquency, The Cambridge Somerville Youth Study, (New York 1951).

5. A. Kadushin, "The Decline in Enrollment in Professional Schools" in Social Casework, Vol. 38, January (1957) pp. 29-31.

6. W. J. Reid & L. Epstein, 1972.

7. A. Pincus & A. Minnahan, 1973.

8. W. J. Reid 7 l. epstein, 1972, pp. 42-48.

CHAPTER V

A SOCIAL PROFILE OF THE STUDY POPULATION

This chapter attempts briefly, in both quantative and qualitative terms, to present the study population's social and economic characteristics. In so doing, I hope to highlight some of their problems and needs. The data presented in this chapter was obtained from the first two administrations of the interview schedule.

Family Structure

The client population consists of sixty-two families. All but seven were nuclear families with both parents present. The other seven had only a single parent. Occasionally, a relative, usually the household head's parent or unmarried siblings, lived with the family.

Housing

All of these households had been rehoused from their former "quarters" which were two-storey blocks of rooms built around squares. In these "quarters" each family had lived in either one or two rooms. Communal toilets and bathrooms were situated at the end of each corridor while communal kitchens were set at the back of the rooms. The squares which were meant to be clean and green were often used as rubbish dumps or public toilets for children and sometimes as a playground too.

These families just prior to this study were rehoused in high-rise public housing. Public housing in Singapore consists of self-contained one, three, four and five-room flats. Other than the one-room flats these have to be purchased. All of the sixty-two families were rehoused within one estate. Like all

modern housing estates in Singapore, this estate had playgrounds, schools, clinics and shopping facilities within easy reach.

Of the whole population, fifty-five percent lived in one-room flats, thirty-five percent in three-room flats while ten percent lived in four-room flats. Thus forty-five percent were in the process of buying their homes. Eligibility for buying these flats is dependent on a family's total income and its ability to upkeep the payment of instalments. Thus those not earning enough, despite their family size, cannot opt for larger flats. The mean size of these families was about seven persons. Considering that fifty-five percent lived in one-room flats, overcrowding was still a problem with this client group. In one-room flats there are no separate sleeping areas for children and parents, nor adequate space for study and certainly no space for play within the home. These problems were less among those living in three and four-room flats.

Financial Situation

All household heads worked with the cleansing services of the Public Health Department or with the Ministry of Environment. With the exception of one working as a driver and another as a carpenter, the rest were working in direct cleansing services. Their wages ranged from S$180 to S$250 per month. The mean total monthly income of the families studied was S$326 per month. (US$1 is equivalent to about S$2.50).

Money was cited by most families as their major problem. Table 1 indicates the number of households stating that they faced indebtedness.

Table 1: Income and Indebtedness of Client Population

Total Monthly Income	Total No. of Households	No. of Households in Debt	% in Debt
100 - 199	4	4	100
200 - 299	10	6	60
300 - 399	18	13	72
400 - 499	16	14	88
500 - 599	6	6	100
600 - 699	4	3	75
700 - 799	2	2	100
800 +	2	2	100
Total	62	50	81

Thus eighty-one percent of the total population had debts of varying amounts. Inadequate income was cited by most of the study group as the reason for their debts. However, with a few notable exceptions, most families had no planned budgets. Expenditure was dictated by money in hand and in the case of groceries there was little sign of bulk buying for a month. Food items were brought as and when necessary, sometimes with cash and at other times on credit. Thus at the end of the month expenditure usually exceeded income.

Education and medical bills were other reasons given for excess expenditure. Here I found that in cases where there were reasonable grounds school funds and health benefits were not often tapped or if tapped, not adequately so. This contributed to parents either borrowing to defray such expenses or simply stopping the need for them, such as allowing a child to drop out of school.

A reason for financial problems that was not often revealed but was nevertheless deduced from observations was that money was spent on drinking. A considerable amount of income was squandered by men who drank. Twenty-two percent of the men in the sample drank either regularly or heavily.

Twenty-one percent of the families in debt stated that they borrowed money to decorate their flats or to buy amenities on hire purchase. Though they tried to clear their debts, repayments were not made regularly but only if there was some money left over at the end of each month.

Household Heads and Spouses

With the exception of seven households, constituting eleven percent of the population, eighty-nine percent of families had both spouses present. In the seven families, three women had died while one had deserted her family. All three men had died, two of natural causes, while one had committed suicide.

Table 2 shows the age distribution of both the husbands and wives in the client group. The figures indicate that most men were in the forty-five to fifty-nine age group while most women were aged thirty to forty-four years. Early marriage and a mean age difference of eight years between the couples seemed to be the norm.

The pattern of marriage was that men tended to marry later in life while women did so earlier. There are two probable reasons for this. First, men preferring to marry women from India had to wait till they had enough money to return to India and to bring their brides back. Women in Indian villages are usually married off early by their families because having unmarried daughters is not a source of pride in the Hindu culture. Families in the Indian villages do not hesitate to give their daughters in marriage to men from Singapore despite a big age difference as men working in Singapore are seen as wealthy grooms.

Table 2: Age Distribution of Husbands and Wives

Age Group	Men	Women
20-24	-	2
25-29	-	5
30-34	2	12
35-39	5	13
40-44	2	14
45-49	14	6
50-54	11	2
55-59	17	4
60-64	8	-
Total	59	58

Second, older men demand less dowry or sometimes no dowry at all, thus it is easier for poorer families who cannot afford to pay dowries to marry their daughters to these men. These seem the main reasons for the presence of younger wives and older husbands and for the large families.

Table 3 shows the educational levels of the spouses as not being high. Despite the type of schooling they have had, i.e. English or Tamil, none spoke nor read English, very few could read and write Tamil but most managed a smattering of Malay. This factor rendered many incapable of communicating with official sources and some social systems. Many relied on their children who were generally just as inadequate.

Table 3: Educational Levels of Husbands and Wives

Years of Schooling	Husbands	Wives
None	17	26
1	-	-
2	16	6
3	5	6
4	-	6
5	8	7
6	8	4
7	-	1
8 or more	5	2
Total	59	58

Citizenship

From the total of one hundred and twenty-four household heads and their spouses, sixteen were still Indian citizens, seven were stateless and the rest possessed Singapore citizenship. This meant that nineteen percent were not eligible for most social service benefits in Singapore.

Alcoholism, Drug Abuse and Criminal Behaviour

Amongst the fifty-nine men, three had criminal records. One man was a drug addict and two had been in prison for secret society connections. A secret society is the name given to any group of members who organise themselves to carry out criminal activities such as extortion, robbery, etc.

Alcoholism was widespread amongst the men; as mentioned earlier twenty-two percent of the men drank heavily whereas only one woman was known to drink. Violence, wife beating and child abuse on the part of men under the influence of alcohol was frequently reported.

Mental and Physical Illness

Two women were known to be mentally ill, and one woman was known to suffer from epileptic fits. Diabetes and high blood pressure were the only commonly reported physical illness. There were no other serious illness apparent in the client group. Skin irritations, and infections, lethargy and infection with head lice were quite commonly reported.

Power Structure and Communication Patterns Within the Families

Without exception the men held the seats of power in the homes. There was a definite division of labour in the tasks performed by men and women. Most activities outside the home were carried out by men, while domestic affairs were attended to by women.

In most situations where there were conflicts, men had the final say. Conflicts between spouses were generally solved with the women withdrawing from the issue or with the women refusing future participation in those specific matters. In cases where the husband was a chronic alcoholic the woman as well as the children simply ignored him. This, however, does not mean that conflicts were expressed and solved peacefully. Domestic scenes of men beating women and children, women shouting and verbally abusing their husbands and children and crashing furniture were part and parcel of the conflict situations.

Levels of marital and sexual satisfaction were usually reported to be "satisfactory" or "not so satisfactory". Though there were extremes on the point of dissatisfaction, none rated their relationships as "very good" or "excellent".

Half of the women did not work (i.e. twenty-nine of fifty-eight) and their main reason was that if they did there would be no one to tend to their young children. Most of the remainder worked for the cleansing services as did their husbands. Two, however, were hospital attendants and one was a lift attendant.

Those who worked as labourers with the cleansing services started work at 6 a.m. and finished at 2 p.m. Thus chores such as cooking and cleaning were either done after work or by older daughters if there were any at home. Thus though there was no need to queue for kitchens and washrooms, in nearly half of the households domestic chores continued late into the day as they used to in the old days. Children waited for meals, meals were eaten irregularly at different times each day, washing had to wait, generally work never seemed to be "done with" for the day.

Family Planning

Though all the men and women interviewed said that two or three children were the ideal number to have, only seventeen families or twenty-seven percent of the whole population had three children or less. The reason given by those who had more was that they had not thought of contraception earlier.

Table 4 shows the number of children per family. The mean number per family was five. A figure quite in excess of the generally desired number, and twenty-nine percent of the families had seven children or more.

Table 4: Family Size

No. of Children Per Family	Frequency	Percentage
1 - 2	17	27
4 - 6	27	44
7 - 9	14	23
10 - 12	4	6
Total with Children	62	100

Table 5 shows the number practising family planning. It should be noted that the users of contraception are all women and not one man has taken this responsibility onto himself. This is in keeping with the belief that these are women's affairs.

Table 5: Contraceptive Practices of the Women

Type of Contraception	No. of Users	Percentage
Ligation	22	40
Pill	2	4
IUD	3	5
Abstinence	5	9
Non-Users	23	42
Total	55	100

The 5 women using either the pill and IUD had decided to limit their families but had not opted for ligation because they did not know the process involved. The five who abstained gave respectively, religion (catholicism: 2) lack of privacy (:1) and not wanting more children (:2) as reasons for their choice of contraception.

Table 6 outlines the reasons as stated by the twenty-three women for their non-contraceptive behaviour.

Table 6: Reasons Given by Non-Users for not Using Contraception

Reasons	Number
Too old to conceive	1
Stopped after side-effects	4
Too much bother	3
Fear/Inadequate information	3
Wrong or sinful	4
No communication between spouses on this issue	5
Want a daughter/son	1
Menopausal	1
Total No. of non-users	23

Obviously this was one of the areas where the client population lacked knowledge, resources and/or motivation.

Attitudes and aspirations

The homogeneity of the clients' comments on their attitudes towards the part played in their lives by fate and

forward planning was striking. The strongly held belief was that they all had to succumb to what "fate" had in store for them. Even those who started off by saying that one could plan one's life, inevitably finished by saying that, all said and done, fate would have its way.

They were poor "because of fate". They had too many children because they were "destined" to do so. They sent their children to school but it was written on their children's foreheads that they "could not study". Fate again was seen as responsible for the fact that their older children had gone into the same sort of work as their parents. Husbands drank and were irresponsible for it was the wives' "fate" that they should be unhappy. Thus it went on; all problems were explained away in terms of "fate".

As for aspirations, the parents had none for themselves as their destinies were sealed. Though they aspired for their children to do better and have better lives, they knew not how to accomplish or achieve these goals and aspirations. The children saw nothing unusual about dropping out of school and working as a labourer, thus perpetuating the life-style which was accepted without question or thought. Those families who did better in terms of housing and money saw it as "good fortune" and could not see the part they had played in gaining some comforts and materially improving their lives.

Use of Resource Systems

When asked specifically which people and which resources they would turn to when in need of help, only one family said that they knew of social agencies that they could turn to if in need. Eighty percent of the client population said that they would rely on relatives and friends for assistance while the remainder said that they had no one to turn to for help.

When hospitalisation or medical treatment was necessary, money was either borrowed to meet the needs or treatment was avoided. Not one family stated having seen a medical social worker. Similarly, not one parent had seen a teacher, school social worker or school health service worker as regards their children. The only helping agents, if any, they had come into contact with were those of the correctional institutions or probation service and these were limited only to those families whose children had broken the law.

The relative isolation of clients from sources of advice and assistance is further demonstrated by the fact that even for those women who were using some form of contraception, none had reached out for it themselves but had been persuaded by nurses during their last accouchement in hospitals, or they had been forced to be ligated to obtain places for their children in a school of their own choice, for Singapore's regulations are such that a ligated parent has priority in choosing schools for her children.

Children

The children in this study comprise a large section of the client population. As mentioned earlier, the mean number of children per family was five, and Table (7) gives their age distribution. Most children were in the six to twenty years age group, with the mean age being twelve years. All the children of school age, i.e. six years old or more, with the exception of three mentally retarded children and one deaf child, had been to school. The total number of children in the client group was three hundred and one; of these one hundred and nine or thirty-six percent were premature school leavers - that is they either left school before or on completion of six years of primary schooling by which time they would be thirteen years old or before they had completed the normal nine years of schooling - i.e. before they reached the age of sixteen years. Table 8 shows the number of children who left school before completing the full six years of primary education and those who left after one to two years of secondary

education. The table also indicates those who were gainfully employed including daughters who have been married off and those who are not employed.

Table 7: Age Distribution of Children

Age Groups (in yrs.)	Frequency	Percentage (to nearest whole no.)
1 - 5	26	9
6 -10	62	21
11 -15	68	22
16 -20	73	24
21 -25	45	15
26 -30	27	9
Total	301	100

Table 8: Education and Employment Status of Pre-mature School Leavers

	No. leaving prior to completion of primary education		No. leaving prior to completion of secondary education		Total	
	No.	%	No.	%	No.	%
No. of school leavers	71	65	38	35	109	100
No. gainfully employer at time of initial interview	43	60	31	82	74	68
No. not employed at time of interview	28	49	7	18	35	32

* The rest of the children were either still in school, of pre-school age or handicapped.

The proportion of pre-mature school leavers (thirty-six percent) is alarming, as is the number not gainfully employed. Only one percent of the total number of children had completed nine years of education and only three had reached "A" level standard - (pre-university level). None had gone on to the University.

With the exception of one, a skilled and two in semi-skilled employment, the rest of the working children were in unskilled jobs similar to their parents.

Several children have had experience with criminal activities and seven had been on probation. At least ten children below the age of fourteen had been in correctional institutions and at least fifteen youngsters above sixteen years of age had been in prison. All these children were males.

The recreational activities of the children in my population were extremely limited. Leisure for them meant sitting in front of a television set, hanging around the corridors, playing unorganised games in staircases landings or merely roaming around the estate. As for the teenagers, the girls often stayed indoors or visited a neighbour's home. The boys seemed to gather in the basements of the blocks, many leaving their homes early in the morning only to return home late at night.

Children's time was not organised into study and play periods. They were left to their own devices and school work was done at home only when there was homework or examinations. Most children at school were reported to be functioning at inadequate levels.

Parents' aspirations for children were low; seldom beyond that of completing school and getting a job. Most parents said that they wanted their children to do better than they did but could not say in what way "better" or how this might be achieved except that the children should do jobs that paid more.

Nutrition

In only two households were children obviously under-nourished. In many others, however, although there were no gross signs of under-nourishment, mal-nourishment did exist.

Breakfast in most households consisted of black coffee with the occasional piece of bread and jam. On festive occasions Indian breakfast was served which would consist of rice pancakes and curry. Lunch and dinner was usually of a basic curry made with vegetable and pulses eaten with rice. Meat was eaten at most only once a week with fish once or twice a week. It was only on festive occasions that meat and chicken would be served together for a meal.

Vegetables were usually brinjals, okra, potatoes and cabbages to name a few; leafy green vegetables were not commonly served. The inclusion of fruits in the diet was rare. Only the very young were fed with milk, the rest had milk only with their tea or coffee. Much of the money for food went into buying rice and spices; for spices, though an expensive item, is an essential part of Indian food.

The Physical Conditions of the Homes

In the one-room flats, in which 55% of the study population lived, sheer lack of space did little to help the physical state of the homes. Except in a few homes where space was sacrificed for a set of living room furniture, most of these flats were sparsely furnished with clothes and other essentials stacked into boxes or the odd cupboard. Most living and sleeping was done on the floors which were covered with linoleum. Though most flats had T.V. sets, none had a refrigerator or electric stoves. In short, modern amenities were minimal.

The cleanliness of these flats was usually satisfactory, although unhygienic conditions did exist.

Only in the three and four-room flats were homes more adequately equipped. It was in these homes that floors were laid with terrazo, with spanking new furniture in the living-room, though not necessarily in the bedrooms. Kitchens were equipped with cabinets and many had refrigerators. Almost all of these fixtures and amenities were being bought on hire purchase. Regardless of the type of flat, there was always present and displayed some items of the Indian social status symbol - stainless steel wares.

Summary

What emerges from this overview of the client population is that 55% of the study group lived in very similar physical conditions to their predecessors. Cramped living conditions still existed after rehousing, the only modest luxury being that of a private kitchen and bathroom.

Money, as evidenced by indebtedness, was still a problem for eighty-one percent of the families, the main reason being inadequate income. Nineteen percent did not possess Singapore citizenship. Though statistically this is not a big figure, in the context of modern Singapore where those who have lived for at least ten years in Singapore can possess citizenship - nineteen percent of non-citizens among a group of people who have lived there longer is a point for concern.

Understandably, educational levels, employment status and earning capacities were low for both husbands and wives - for after all they were products of the indenture system. What is disconcerting is the perpetuation of this pattern into the next generation, with their children. Though the independent variables of availability of schools, laws against child labour, better health and social facilities to name a few, were more conducive to upward social mobility, the educational and employment status of the offspring were still low particularly in the context of the generally high literacy rate, occupational opportunities and occupational mobility that exist in Singapore today.

In Singapore where the ideal of a small family is being so rapidly achieved and where three children is the norm - a mean family size of five as amongst this group is a figure of note. Again family planning, a proud symbol of development in Singapore, has not, it seems, fully reached this group of people. Forty percent of the total study population did not practise any form of contraception.

Home management, in the case of the fifty-five percent who lived in one-room flats, was not affected by rehousing. The bare, bleak conditions of their former quarters - and long before that of the "lines" - were still evident. Attitudes were fatalistic and apathetic, unlike those of the larger community of independent Singapore. Where aspirations existed, skills to achieve them did not. Even when upward social mobility and satisfaction with life was achieved, it was due to more members of the family earning similar incomes rather than any conscious planning.

Problems created by alcoholism, ineffective role playing, bad marital relationships and delinquent children were, generally speaking, left unattended.

Other than more spacious and comfortable living conditions for forty-five percent of the client group and the presence of television - one sign of the technological age - there was little evidence of the "clean, green and rugged" living that typifies the developed society that Singapore has become.

CHAPTER VI

THE SOCIAL WORK INTERVENTION

This chapter deals with the input of social work with the two treatment groups. It outlines the techniques used; the type of problems identified and worked with; the number of problems worked on; the methods employed and the resources tapped. A description of work with the "intensive treatment" group and the "less intensive" treatment group is given for each separately and respectively. It must be noted that the intervention processes were the same for both the treatment groups - only the time spent and intensity varied - thus the ensuing discussions on process and techniques apply to both groups.

Some Clarifications

To record every aspect of social work intervention showing its relevance to the achievement of goals is not easily accomplished as the network of social work activities is too complex. To avoid ploughing through masses of information on process, input is described by highlighting the major areas worked with, methods used and examples of resources tapped. However this does not imply that factors contributing to the major problems were not attended to. The aim of social work in this study was to increase self-awareness and self-worth which in turn, it was hoped, would lead to better social functioning. This aim was implicit in every task set and achieved. For instance, if an area of inadequacy was identified and if the task was to overcome this inadequacy - the process of enabling included the objective of helping the client to recognise why the inadequacy had come about; what he could do to resolve the problem and if the task was achieved - how he had achieved it. This I believed not merely alleviated the immediate problem but in the long term increased the client's awareness and demonstrated to him potentials in his coping capacity. An awareness that might spur him

on to cope better with his other needs and other areas of his life.

In some cases fatalistic attitudes hampered initiative and motivation. Thus if a client was enabled, for example, to take positive action in limiting her family size, reflection initiated by myself as the worker would I hoped enhance her perception of the part she herself played in controlling what she previously had believed to be controlled by destiny.

Thus whenever and wherever possible value-based and/or psychological problems were brought to the surface by enhancing the client's awareness and through trying to demonstrate that the client had the abilities to cope.

Although there were problems of alcoholism and drug addiction among my client population these were excluded from intervention. As stated previously these were not seen as areas that could be worked with within the model used in this study.

The Process and Techniques of Social Work Intervention

The Social Work Practice Model, upon which I drew heavily, uses the systems approach as a basis for identifying the various parties involved in social work. I used this approach, likewise, in working with my client population. The different systems involved in this social work process were the change agent system, the client system, the target system and the action system. This approach was useful as it facilitated the planning of intervention by clearly indicating the different parties that had to be involved in problem solving. For example, if a problem of budgeting was identified the plan of action would probably need to include only the change agent system and the client system. However if a problem of employment was to be worked on, then from the start one could identify the change agent system, the client system and the target system as systems which have to be mobilised.

As regards the change agent system in this study, it consisted of only myself as I was working alone, unattached to any agency, whereas in the Social Work Practice Model the change agent system is the agency employing the change agent. The client system in my study included individuals, families and groups. The target system consisted of people and organisations that the change agent (myself) needed to influence in order to accomplish the goals of her change efforts. Finally the action system consisted of the change agent, client systems and target systems; thus the action system was the means of accomplishing tasks and achieving goals.

As regards the theoretical knowledge bases, two main sources were drawn upon to help task achievement. One was the knowledge of practice skills and interventive techniques and the other was knowledge of theories of behaviour and the dynamics of interactions. As advocated by both the Task Centred model and the Social Work Practice model, no one set of theories was adhered to exclusively, but theories appropriate to circumstances were selected and used.

Practice skills used in the treatment process included: identifying and stating problems, analysing the dynamics of the social situation, bargaining and collaborating on goals and targets, determining strategies, implementing change efforts and maintaining achieved change.

Data collecting skills included interviewing and observation techniques. Conscious and purposeful decisions had to be made when forming action systems - decisions as to the most effective size, composition, and techniques necessary to facilitate action had to be made.

The Use of Relationships

The relationships I formed with the people in the different systems were the means through which activities were carried out and goals achieved. Specifically two types of relationships were used in the goal setting phase and in the process of forming action systems, namely the bargaining relationship and the collaborative relationship.

To illustrate the use of the bargaining relationship in goal setting, let us take "Family O". In this family, the mother wanted he children to receive help with their school work as they were performing rather poorly at school. The bargain was that in order for me to help her achieve this goal, she in turn had to set herself the tasks of organising her time and her children's time to have them ready, at a certain time, three days a week to attend the study centre. In "Family O" the mother was habitually late in terms of preparation and serving of meals, washing and so on. Thus, the children waited to be fed, were subsequently late for school, and had their lunch late in the day. If this pattern persisted, they would often not be in time for the study centre. The mother was also asked to set herself the task of providing adequate and balanced meals for the children. Towards achieving this task she had to join the women's group to learn of nutrition. Thus in the bargaining process three goals were established for "Family O" - first, the mother to organise her time better, second, for the mother to provide adequate meals and third, for the children to receive tutorial help. This process then led to a collaborative relationship between "Family O" and the worker, in which agreement was reached on these tasks and a contract was made to achieve them within a stipulated time. Collaboration was only achieved after the client system in "Family O" was helped to see the inter-relationship between the tasks.

In another case where the bargaining relationship was used, the case of "Family M", the bargaining was not with the client system but with the target system. In "Family M" money was a major problem. Debts had accumulated and showed no sign of being cleared, but only of increasing. One of the tasks set toward achieving this goal was for "Family M" to apply for a waiver on one child's school fees. The child's elder sibling was advised about the procedure for applying for a waiver and was sent off to the school to do so on behalf of his young sibling. However, the application was turned down by the school principal. At this stage I accompanied the mother to the school to investigate the reasons for this rejection. The principal's stand was that the child did not attend school regularly and was also doing poorly, thus such a waiver seemed unjustified. A bargaining relationship had to be formed with the target system here.

It was not a simple straightforward process of me saying that if the target system approved the application, then the client system will ensure regular attendance and better performance. First, the target system had to be persuaded to see the pressures that lack of money had on "Family M's" functioning; then I acted as a mediator between the principal and the mother in reaching an agreement that regular attendance would be ensured while the principal approved the waiver.

Such bargaining relationships were often resorted to in the task setting phase. Families could often specify their goals but could not see the necessity of setting tasks to achieve these goals. Thus especially in this phase of the process the bargaining relationship proved to be useful.

The third type of relationship that was used was the conflictual relationship. The Social Work Practice model envisages a breakdown in the bargaining relationship which will not lead to collaboration, and allows for a conflictual relationship.

For this study, it was only in the case of one family that this relationship was used. However, it was not when bargaining broke down but when the collaborative relationship ceased to exist. What occurred was that the client system, "Mr. Y", consciously contravened the contract sufficiently to cause distress to the action system, and a conflictual relationship had to be established to achieve the goal of the action system. This was the case of a widower who had agreed to the goal of remitting regular financial payments for the maintenance of his children who were under the care of their grandparents in a different household. In order to achieve this goal, the tasks of budgeting and securing a part-time job were set. I worked with this client system towards accomplishing these tasks so that he would be in a better financial position and thus be able to contribute financially to the upkeep of his children. The client achieved these tasks, but wilfully avoided making contributions for his children. When persuasion failed, I, as the change agent, formed a conflictual relationship with the client. As his children and their grandparents were also my clients,ttheir action system was modified to take legal recourse to resolve this problem. As "Mr. Y" did not co-operate or collaborate with me, intervention or the goal achieving process for this client was terminated.

Practice Skills

On many occasions several action systems were formed to deal with one problem, thus maintaining and co-ordinating action systems was another practice skill that was required. For example, in the case of "Family B" where the goal for the wife was both to gain sufficient knowledge of family planning and to be motivated towards adopting contraceptive behaviour, she was therefore involved in two action systems. One was related to her achieving the task of gaining knowledge from the women's group and the other action system comprised her and myself focused towards achieving the motivational goal. Thus I had to be aware

of her responses in the group situation, co-ordinate them with her responses in the individual sessions with me, all aimed towards achieving the goal of motivating her to accept family planning.

Exerting influence was another skill used in the treatment process. Techniques used to influence behaviour, attitudes and beliefs included inducement, persuasion, use of relationships (as discussed earlier) and encouraging clients' relations on achieved tasks.

It was not often that I resorted to inducement in influencing behaviour, but in the case of "Family K" where the wife was mentally ill, inducement had to be used to achieve a goal not set by the client system but by me. In this family, which incidentally belonged to the control group, there were eight children, the youngest being two years old. Three boys had already been on probation for delinquent behaviour. The wife had been mentally ill off and on for several years. There were periods when she was well enough to cope with basic "living chores" while at other times all she did was to sit still and say nothing. Neither she nor her husband used any form of contraception. The need was to ensure that the wife did not conceive again. Neither she nor her husband wanted more children, but they were not prepared to do anything about it. The man did not want to hear anything of vasectomy nor did he want to ensure that his wife used contraception. It was at this stage that I applied a great deal of pressure and persistence to practically force the client system into action.

Techniques used to help clients put "insight into action" included encouragement, direction and intervention. Directions were given to initiate actions that clients had not considered towards achieving tasks. And intervention was used when concrete suggestions alone were not enough but when the workers' actual participation was required in accomplishing tasks.

For example, encouragement was often used with wives who needed to participate more actively in the marital system and sometimes simply with those who needed to verbalise their needs more forcefully. Direction was often used, especially in those families in the "less-intensive" treatment group. "Girl G" wanted a job, thus her task was to find one or at least find out about one. Without help from me she did very little. Hence, I had to tell "Girl G" to go to the Labour Exchange or even to the Area Office of the housing estate to merely ask for information. Soon after this simple direction, "Girl G" was waiting for me with application forms in her hands. She wanted very much to work as a car-park attendant, so she had found out where to go from the Labour Exchange, got the forms and now needed help in filling them out. Direction was all that was given with yet another client, "Boy C", who was doing rather well at school but wanted to ensure that he could go on to pre-university. His main problem was that his family was not able to afford the money for it. It was not necessary in this case for intervention at all. What I did was to explore the various possibilities that he could tap. When I came up with one good source, an educational trust that was run by a Hindu organisation, I suggested to "Boy C" that he write to this body addressing one person in particular. Then I gave him a reference letter that he could attach to his application. He was motivated enough to immediately carry out this task on his own.

My active participation was often needed when working with families in the intensive treatment group. For example, for families D, F and N it was necessary for them to have the right documents to apply for citizenship. I personally sat down with them to sort the papers out, went with them to the Registry and participated actively through the whole process of application. I did this after deciding that suggestions alone would not help as this particular government authority was seen as being formidable, very formal and all three clients could not be assertive enough to talk to the officials themselves. Furthermore, there

was much apprehension on meeting language problems in this office and it was not enough to convince them that a Tamil speaking person would surely be there and that they could always insist on having one to speak to. Clients could not see themselves as being so assertive. In this task achievement process, when I accompanied them I did not do all the talking for them but informed the Chinese official who met us that the applicants could not manage sufficient Malay and thus it would be preferrable if an Indian official attended to them. The person who met us was only too glad to ask an Indian personnel to attend as after all this was more efficient. Clients here were thus enabled to see for themselves that sometimes all that was needed to be done was to ask.

Termination

As stipulated by the task centred brief treatment approach, termination was kept in sight from the start. Evaluating change efforts, disengaging from relationships and stabilising changes achieved were all part of the process.

Client systems and target systems were informed that I would leave after six months of intervention. I believe that this process was made easier for me because clients knew well enough that I was a student and not a full-time social worker, and thus could see and accept my departure. Towards the end there was some apprehension on the part of clients who needed further support but the way I put their minds at ease was to inform them of specific agencies that they could go to if further assistance was needed. Thus on the whole termination was not very painful. At least not so for the client systems. However I did experience some feelings when I had to withdraw from the children. Three children in particular were worked with intensively. And with one, where I felt that change efforts had not been stabilised sufficiently, I worried.

I have tried to illustrate to some extent the process of my work with the client group. I am sure the nuances of social work intervention especially in the area of relationships are not illustrated clearly. How does one illustrate the effects of a touch of hands that shows sympathy or reassurance, a smile that shows warmth and acceptance, a frown that shows disapproval, or for that matter a client's acceptance of the social worker by the offer of a glass of water, or of a paper fan because they see the worker uncomfortable after trekking up and down the flats or when they offer to share a meal as some said, "isn't it about time you ate?". It is not easy to describe in words the effects that all these little gestures have on the task or goal setting and achievement processes. Nevertheless these are part and parcel of the diagnosis and treatment processes in social work.

In order to illustrate more vividly the actual process of social work intervention, two case illustrations are included in appendices IV and V. One is selected to illustrate the "intensive" treatment and the other as an example from the "less intensive" treatment group.

Social Work With the "Intensive Treatment" Group

To reiterate, input with the group took the form of:-

(1) working with as many problems as possible

(2) clients being seen at least once a week and sometimes more

(3) change agent actively participating and being directly involved in the task achieving process. For example, clients were not just given concrete suggestions on the means to achieve tasks but were assisted in putting suggestions into action.

(4) intensive counselling as opposed to advocate counselling.

The categories that follow list the number of problems diagnosed and worked on, type of problems, the methods used and the resources tapped. The number of problems actually indicate the goals and tasks set. The problem typology includes the number of families who presented these problems. Methods used include all of the techniques that have already been discussed. As for resources tapped, examples will be given to show how this was executed.

Problems Diagnosed and Dealt With

	No. of problems per family	No. of problems dealt with
1.	3	3
2.	3	3
3.	1	1
4.	0	0
5.	5	5
6.	5	5
7.	4	4
8.	4	2
9.	2	2
10.	4	4
11.	5	5
12.	3	3
13.	0	0
14.	1	1
15.	4	4
16.	14	14
17.	6	6
18.	5	5
19.	5	5
20.	3	3

Type of Problems Handled

Problems Assisted with Practical Help & Services	No. of Families	Problems Assisted with Counselling	No. of Families
*Income, Debts, Budgeting	11	Income, Debts, Budgeting	14
Knowledge & Use of Social Resources	15	Knowledge & Use of Social Resources	2
Citizenship	5	Role Performance	9
Employment	4	Inter-familial Relationship	7
Illness	2	Communication	5
Nutrition	5	Social Relationships	5
Contraception	5	Self-Awareness, Self-Image & Self-Reliance	11
Children Under Achieving in School	8	Attitudes, Values, Inhibitions	7
Lack of Study Space	9	Emotional Distress	3
Lack of Play Space	9	Socialisation of Children	5
Lack of Educational Stimulation	8	Realisation of Expectations	7
Lack of Play	6	Lack of Motivation	7
Home Organisation	7	Social Isolation & Loneliness	3
Housekeeping	4	Knowledge and Attitude of Family Planning	4
Children not in School	3		
Needs of the Elderly	1		
Personal Hygiene	7		
Financial Maintenance of Children	1		

*N.B. Figures in both categories include the same families as usually intervention was a combination of both types of methods.

In coping with the various problems and needs other agencies were contacted. Some of those were included in the target systems while others were tapped for both material and supportive provisions and services. Other agencies contacted included:

1. The Area Office of the Housing Authority
2. The Labour Department
3. Employers in factories
4. The Social Welfare Department - relevant services
5. Education authorities
6. Schools - principals and teachers
7. Citizenship authorities
8. Hospitals, clinics
9. Medical Social Work Service
10. Voluntary Agencies e.g. Salvation Army, Catholic Welfare Service
11. Independent scholarship-fund organisation
12. Volunteers
13. The Legal Aid Department
14. The Family Planning Association
15. School Social Workers
16. Hindu Organisations
17. Labour Co-operatives.

The process of using social resources can be illustrated by the following cases. For example, when "Client F" was in need of a part-time job that was not too far from her home, a nearby industrial estate was visited. The client and I scouted around looking at the notices that are customarily put up by factories when in need of employees. Having found one suitable situation vacant, we proceeded to apply, and I made telephone contact with the person in charge to expedite the client's application.

In the cases where women and children needed delousing treatment a nearby out-patient clinic was contacted and services were secured.

In the case of "Family Z" where the children suffered from under-nutrition, the Catholic Welfare Service (a voluntary agency) was contacted to secure free provisions of rice, oil and milk. In another case where "Mr. Y" (already mentioned) contravened the contract, his children were helped to secure free legal assistance from the Legal Aid Department, for the help of this Department was needed to have client "Mr. Y" legally bound to support his children.

The Women's Group

During the problem searching and task formulating phase, several areas of common need surfaced among this group. Not only were there common needs but there were indications that a reciprocal resource was needed, especially among the women. For example, there were instances when women wanted to do something but did not dare do so for lack of company and support. Then again there was a woman who due to illness and low self-image, isolated herself from her community, thus depriving herself of the concern and support of that community. I felt that for these women, shared experiences would help to reduce doubts, anxiety and fear of the unknown. Finally, for maximum use of time and expertise, I considered that some issues, such as nutrition, hygiene , knowledge of social resources and family planning, could be best dealt with in a group situation rather than at a casework level.

For reasons outlined above, an action system consisting of a group of 12 women was formed. The group consisted of only 12 women from the "intensive intervention" group as they presented common needs and were diagnosed by me as being most receptive and likely to benefit from groupwork. In the case of the rest of the families, there was either no common need or if there was there were reasons such as husband's prohibition in

joining the group. For the "intensive treatment" group, the approach was more focused and I often intervened to restrict too much of a free flow to enable the group to focus on specific tasks in hand.

The group met regularly - once a week. For all discussions other than those relating to sexuality and contraception, we used the landings at the end of a corridor as a meeting place. I chose this meeting site as it was a natural place for the women to meet and chat. The landing was in the middle of the corridor, thus becoming a natural mid point. If I had specified a different setting, the meetings might not have taken place as this would have meant that the women had to make extra efforts to get there. For discussing such topics as sexuality and contraception, one home was selected from amongst the group. This was easily achieved because the need for a more private place came up later in the group meeting, and furthermore, it was not unusual for these women to drop into each other's homes.

Record of Service

Group: The Women's Group

Period covered - 5 months
No. of members - 12
Change agent - 1

Tasks:

1. To gain knowledge of and use relevant social resources.
2. To be informed about and practice acceptable levels of nutrition and hygiene.
3. To explore maximum use of living space.
4. To learn budgeting.

Purpose:

1. To gain self-awareness, knowledge and skills to cope with "life's chores".
2. To become a resource within themselves for themselves.

5. To increase awareness of sexuality.

6. To gain knowledge of contraception.

7. To adopt contraceptive behaviour.

8. To offer mutual aid.

Summary of Work Done with the Group

As the women came from similar backgrounds and were quite used to dropping in on each other and chatting, it was not difficult to form this group. The difficulty lay in keeping women from the other treatment and control group from flowing into this action.

Practice skills were taxed in helping the group to settle down and collaborate. Often the group members had to be reminded to keep tasks in focus and to realise the pressure of time to achieve these tasks.

It was agreed that for tasks 1, 2 and 6, I would be the resource person to diseminate information. Information was given in what I hope was a simple and clear manner using words that were familiar to clients, with visual aids used to illustrate certain facts. Starting the task achievement process by tackling the issues of social resources, nutrition and hygiene went down relatively easily as these were not seen as intimate and self revealing areas. As the high cost of living in flats affected all members, enthusiasm was shown whenever resources providing material aid and low cost services were discussed. This phase also gave the group time to become accustomed to consciously discussing and thinking of areas that were seen as affecting individuals.

However, there were inhibitions and anxiety shown in using, for instance, the SILO supermarket (Singapore Industrial Labour Organisation Co-operative - where staples such as rice, oil, etc. were sold at a lower price). None of the group had ever used a modern shopping facility such as this before. A familiarisation tour was organised.

In the same way when hygiene was brought up, head lice were stated to be a plaguing problem, and certainly part of the usual scene seen at the doorsteps of these flats was women "picking nits" from each other's hair. Personal hygiene and the advantages of the use of simple soap to wash hair were discussed. To sensitise a group to the various services available in a government clinic, the group was informed of the delousing treatment offered. Information was received with much surprise as clinics were known to be places one went to only when one was sick. Here again appointments were made and kept to secure delousing treatment.

The group did not move much in the area of the physical organisation of the home. Here their feeling was, and rightly so, that there was not much that they could do. The group wanted a total solution to this problem which could not be found. Simple techniques to maximise space by rearrangement of furniture and so on were discussed, but were not well received.

Budgeting brought out negative feelings from the group. Much time was used by members to ventilate frustrations about husbands' drinking habits, children's educational costs, the high cost of high rise living and so on: a therapeutic exercise in itself. Enabling the group to see small savings and bulk buying, for example, as being helpful, were not achieved until much later. Four months later two members had successfully cut expenses. Encouraging them to share their experience with group members did indicate signs of recognition and acceptance of this coping mechanism.

It was easier to motivate women into contraceptive behaviour than it was to discuss sexuality. Having a mixed group of "contraceptive users" and "non-contraceptive users" proved to be the greatest strength in this group. Sharing the experience of using very simple procedures that cost so little money, inconvenience and side effects influenced the "non users" into action of the five "non users". Four, by the end of the treatment period, had adopted contraceptive behaviour. In terms of mutual aid, there was co-operation not only in the physical sense but a constructive sharing of distress enhanced the women's awareness that their problems were not particular only to themselves, but were experienced by others too. The awareness of the fact that some problems could be contained (as demonstrated by some women in the group for example in limiting family size) helped to raise the women's confidence in their coping capacities. This was the greater of the task achievements.

The Study and Play Centre Project

In terms of a community need, the most pressing need concerned young school age children. Most children in this age group were under-achieving at school. In addition to problems involving money, relationships, etc. there was a total lack of study and play space and a lack of educational guidance and stimulation, coupled with the fact that children did not use playgrounds within the estate, nor was there play that helped in releasing energy or in initiating any constructive purpose.

Thus I felt the need for a space that these children could use to do their homework and just sit and read, to have someone who could provide help and stimulation for learning and someone to help organise constructive play.

Scouting around for resources brought to my attention a large shop house within the estate which had been turned into a community hall by the Salvation Army. Contact with its headquarters resulted in this agency providing the space and

a para-trained worker three times a week to help realise the goal of providing a resource such as this within the estate for this community.

The project was put into operation by recruiting volunteers from the Volunteers Bureau of the Social Welfare Department to help the worker of the Salvation Army to man the study and play centre. Programmes were planned in co-operation with the centre worker, and volunteers were deployed to implement them.

Material aids such as books, play equipment, etc., were obtained from a child welfare agency.

The para-trained worker was informed of the case histories of the children and volunteers working with the children were also briefed. Two older children from the client group were enlisted as volunteers. These two youngsters needed a place to go to and something to do. Thus in becoming volunteers they were, in meeting their own needs, also providing a link between their community and the other volunteers.

The major difficulty faced in this project was the same as that faced in the women's group. Children from the other treatment group and the control group turned up in force to join the centre. Having for the first time a place to go to other than their home was an instant attraction. Furthermore, reports of "fun" from the other children drew the crowd. More than the physical effort required in turning these children away, the moral conflict was harder to cope with, not only by me but by the centre's worker and the volunteers.

The outcome of this dilemma was the decision of the centre's worker to throw open the doors to all children every Sunday for purely recreational purposes. Thus three days a week children from the "intensive treatment" group used the facility for structured help and once a week the children from the total study population could drop in whenever they wanted.

The centre's worker recruited her own volunteers to help run her Sunday sessions. Though a resource was made available and needs of one section of the client population were met, in terms of the community's total needs it was still inadequate.

However, one step had been taken in meeting the community's need. Different community resources were tapped and co-ordinated into providing this service. Furthermore, another helping agency's attention was alerted to the needs of this particular community.

This project was not terminated at the end of the treatment period but the professional control of the project was transferred to the centre's worker so that she could continue with the work.

Social Work with the "Less Intensive Treatment" Group

The techniques and qualifications discussed earlier apply to the work done with this group also. However, in terms of quantum, the input differed as follows:

1. Only the problems that were urgent and which severely affected family functioning were worked on.
2. Clients were seen only once a fortnight.
3. Though my participation was involved and active in the explorative and task formulating phase, it was not so active in the task achieving process.
4. Help was in the form of general support and advocacy, rather than as an agent actively involved in effecting change. I was more a "referring body" meaning that I identified and referred clients to sources from which they could receive services for their needs.

Presentation of input is in the same format as that of the "intensive" group.

Number of presenting problems and
No. worked with

No. of Problems Diagnosed	No. of Problems Helped
2	2
3	2
3	3
1	1
4	2
3	2
3	3
9	8
1	1
3	2
9	6
9	3
5	5
5	4
5	4
5	4
5	4
8	4
4	3

As with the earlier group, alcoholism was a problem that was not worked on. The following table presents the types of problems that surfaced and that were dealt with. It can be seen from the typology that this group's needs are similar to those of the earlier group. Though these problems were the focus of social work, to reiterate, intervention was not as intensive and whenever counselling was used it was more on an advocacy level.

Type of Problems

Areas rendered with practical help & services	No. of families	Areas rendered with counselling	No. of families
Income, debt, budgeting	5	Income, debts, budgeting	7
Knowledge of social resources	11	Attitudes, values	7
		Relationships	5
Employment	5	Self-awareness & self-reliance	6
Citizenship	1		
Nutrition, housekeeping	9	Stress	7
Contraception	5	Loneliness	1
Health	3	Knowledge and attitude of family planning	3
Educational fund	2		
*Lack of study and play space	10	Socialisation of children	2

* N.B. Though ten families presented this problem, only one was helped as resources in this area were limited for this group receiving "less intensive" treatment.

This group, like the intensive treatment group, required the services of other social resource systems too. However, unlike that group, clients were only given concrete suggestions, information on services available and a referral to the agencies. The resources that clients were referred to are listed below:

Resources Referred To

1. The Labour Department
2. The Social Welfare Department - relevant services
3. Family planning clinic
4. Volunteers
5. Indian social service organisations
6. Labour co-operatives.

As in the earlier group, the women belonging to this group were also formed into a group to achieve certain tasks. However, the goals and tasks were limited as demonstrated by the following record of service. Here too the same reasons as in the former apply for the selection of the members. Another staircase landing was used as a meeting place for this group. The process of the group however, though focused, was not as restrictive in terms of flow as the former was.

Record of service

Group: The Women's Group (2) Period covered: three months
No. of members: nine

Tasks:	Purpose:
(1) To gain knowledge of service (2) To be informed of nutrition (3) To gain knowledge of contraception.	Knowledge of social services, nutrition and family planning to facilitate relevant areas of social functioning.

Summary of Work

This group was formed purely for the purpose of helping the group to gain information. I believed that giving information to a group as a collective unit might in itself spur the members to put knowledge into action when they had the support and strength of being together.

Information on resources, explanations of contraception and discussion of nutrition were undertaken in a very informal atmosphere. To an unknowing observer, the group's sessions would have seemed like "a bunch of women gossiping". This approach helped to ensure a free flow of interactions, allowing an atmosphere where inhibitions could be overcome. The purpose of guiding the group into developing a less structured and more informal format was to dispel what they had known or experienced of social work previously. As mentioned before, most of the client group's experiences with social work and social systems were in the area of correctional services. Thus the mention of helping agents often brought to these people's minds probation and prison officers. Thus, due to the nature of problems dealt with by these social work agents, social workers and social systems inevitably meant formality and thus apprehension.

The one major problem that was experienced in this group-work's process was the comparison the members themselves made of the extent of my involvement with them as opposed to those of the "intensive treatment" group. As these members were in close proximity to those of the other women's group there was initially much dissatisfaction at the "lack of interest" shown by me. The source of dissatisfaction was my inactive participation in their task achieving process. I explained the purpose of my research and its objectives. The members, however, found it hard to accept why I had to try and see if they could do things on their own. This created doubts over my concern for them, a feeling that I could empathise with.

The only basis that I had to fall back on was the strength of my relationship with the individual members. This I hoped would ultimately help cement the trust the group had shown in me. Nowhere else in my work with the client group was my conflict between practice and research brought out so acutely.

Though there was no sign of hostility, there certainly was a certain amount of coolness that I did not experience with the other group. However, as the process proceeded, members relented, though there was the occasional joke about "how the worker was trying to learn from them" and how they had become "books".

By the end of the treatment, all the members showed signs of having used some of the resources they had learnt. They used for example, the SILO mart and school social services. Of five women who needed contraception three responded by using contraceptives.

The women had used each other as support for achieving some of their tasks. For instance, three women who first went to the SILO mart did so together. And the three who went to the Family Planning clinic went with one other "friend". Thus without force or pressure from me a system of mutual aid did evolve within the group.

Summary

Social work input in the client population has been described in terms of processes of treatment, number of problems worked with and the types of problems that were presented. In order to illustrate the process of treatment, snippets from various cases have been presented, and the use of resource systems have also been illustrated.

I have stated that to record the process of intervention is not so easy a task as the essence of intervention will invariably be lost. I am very aware of this inadequacy in presenting the input of work with the client groups. In order to try and overcome this inadequacy, sample case illustrations of treatment have been presented in appendices IV and V.

So often in social work intervention the tangible inputs can be easily recorded, but the nuances and subtle interplay of techniques used to achieve even some of these tangible results often elude presentation. I hope that this might be remedied to some extent by these case illustrations.

CHAPTER VII

THE EFFECTS OF SOCIAL WORK

Introduction

This chapter attempts to answer the questions posed in this study. The findings presented were arrived at after comparative analyses of the families' functioning levels before and after social work intervention.

In order to facilitate the presentation of the findings, functioning levels are divided into three categories of "above marginal", "marginal" and "below marginal". As stated earlier, functioning levels were rated on a seven point scale. The scale points of seven, six and five are grouped to form the "above marginal" category; the "marginal" category comprises scale point four, while the scale points of three, two and one are grouped to form the "below marginal" category. Although in terms of making judgments on levels of functioning for each family, the judge's scores and my own varied in terms of scale points, they were always within the same overall category of functioning. For example, where I scored a family on scale point one, the judge had rated the same family similarly at a near inadequate level but at scale point two. Thus although there is a difference of one scale point between our ratings, the family nevertheless is assessed by us both to belong to the "below marginal" category of functioning. For ease of presentation, therefore, it is only when demonstrating the overall effects of social work that the judge's scores and my own are both presented. In all other instances, my ratings alone are used to illustrate outcome.

The research questions

To reiterate, the questions posed in this piece of action-research were as follows:

1. Did rehousing alone improve the social functioning of the study population?
2. Did social work intervention help?
3. If so, what intensity of social work intervention benefited what sort of families and in which specific areas of family functioning?

The effects of rehousing

To find out if rehousing alone would improve families' social functioning levels no contact was maintained with the study population for six months after the initial phase of interviewing.

The table that follows shows the functioning levels of the study population immediately prior to rehousing and six months after rehousing but before the start of social work treatment.

Although rehousing per se had not made a significant difference to overall levels of functioning as assessed by my methods, the forty-five percent who had moved into the three and four-room flats indicated in their responses that they felt that rehousing had improved the physical conditions of their living environment and had led to a more physically comfortable life. The other fifty-five percent, however, who had been rehoused in one-room flats felt that other than having a private kitchen and bathroom, rehousing had not greatly improved their lives. Cramped living conditions, financial problems, and marital problems still remained the same as before rehousing. Indeed, twenty-one percent of the eighty-one percent who faced indebtedness stated that debts were incurred specifically because of rehousing as living costs were higher.

Table 9. Post-rehousing and pre-treatment scores

Category of functioning	Scale Point	Post-rehousing Score (No.)	(%)	Pre-treatment Score (No.)	(%)
below marginal:	1	3		3	
	2	5	21	5	21
	3	5		5	
marginal:	4	16	26	16	26
above marginal:	5	18		18	
	6	12	53	12	53
	7	3		3	
Total:		62	100	62	100 *

* The movement is evident from the scores indicated above, with twenty-one percent functioning at the "below marginal" level and twenty-six percent functioning at a "marginal" level, and fifty-three percent at an "above marginal" level although most of these were at the lower end of the category.

Further, during the six months non-intervention period, six families had moved out of this housing estate to elsewhere as they could not cope with the increased cost of living.

Evidently, although rehousing had improved the physical conditions of living for the people who were able to move into larger flats, inadequate space and cramped living conditions still persisted for those who could not afford any other than the one-room flats.

However, from another point of view and considering the social resource systems that had been tapped within the new estate, namely the Salvation Army's community hall and the SILO Supermarket, rehousing had had the effect of placing these resources within the easy reach of the study population. In addition, rehousing had also provided more playgrounds and a cleaner environment. If all of these facilities could have been properly used by the study population of their own volition, rehousing would have improved their living standards in at least some areas. As it was, these resources were not used prior to treatment and their effects were not, as yet, felt by these people.

The results of social work intervention

After six months of non-intervention social work, treatment began for the two treatment groups. As stated earlier the conventional long-term approach seemed to have had little effect on these families. Thus the study proposed to find out if short but focused social work intervention, aimed at working not only with individuals but with groups, would prove more beneficial. The following table presents the pre and post treatment scores given by the independent judge and myself for the families in the two treatment and one control groups. It can be seen from the table that the scores given by the judge and myself respectively demonstrate that seventy-four percent and sixty-seven percent of families in the two treatment groups had improved by one scale point or move in their social functioning as compared to only ten percent of the untreated control group.

None had regressed in social functioning in either of the treatment groups, although five percent of families in the control group were assessed as functioning less than before. The ten percent in the control group who improved did so only after some social work intervention. This figure represents two families whom I felt for ethical reasons could not be left completely

out of the treatment process. Their circumstances were such that at least minimal intervention was required. I found it morally unacceptable to stand by and do nothing in these two cases, given the extent and nature of the problems confronting these particular families. Thus I had to confront the dilemma facing anyone engaged in action-research and felt that, for the sake of my professional integrity, I had to confound the research design.

Table 10. Movements in the treatment and control groups

Direction of movement	Intensive Treatment Group		Less intensive Treatment Group		Control Group	
	Judge %	Worker %	Judge %	Worker %	Judge %	Worker %
Improved (1 scale point or more)	86	71	62	62	10	10
No change	14	29	38	38	85	85
Regressed (1 scale point or more)	-	-	-	-	5	5
Total	100	100	100	100	100	100

The following table shows the movements by scale points made by families in the three groups. The scores for this table are those assigned by me.

Table 11. Pre and post test scores for the treatment and control groups

Category of functioning	Scale Point	Intensive Group Pre-test (No.)	Intensive Group Post-test (%)	Less intensive Group Pre-test (No.)	Less intensive Group Post-test (%)	Control Group Pre-test (No.)	Control Group Post-test (%)
Below Marginal:	1	1	10	2	14	2	40
	2	-				3	
	3	1		1		3	
Marginal:	4	9	43	1	5	4	20
Above Marginal:	5	6	47	10	81	1	40
	6	4		5		6	
	7	-		2		1	
Total		21	100	21	100	20	100

The table shows that in the "intensive" treatment group the ten percent that were functioning at "below marginal" levels had all moved out of this category after treatment, and that of the forty-five percent who were at "marginal levels" before treatment, only ten percent remained in this category after treatment. The "above marginal" category had increased from forty-five percent to ninety percent by the end of the treatment period.

Thus social work intervention, and more specifically "intensive" intervention, did seem to have helped these families improve their social functioning levels. This outcome compared to that of the control group strengthens the finding that social work did affect functioning. In the control group the forty percent in the "below marginal" category before treatment remained there after treatment. However of the twenty-five percent in the "marginal" category prior to treatment, twenty percent remained after treatment. The thirty-five percent in the "above marginal" group increased to forty percent after treatment. The percentage that moved is very small and considering too that this outcome was contributed by families that had intervention, the conclusion here is quite obvious - that without social work the families showed no movements.

In the "less intensive" treatment group there seems to be no movement in the "below marginal" category, although five percent of the families in the "marginal" group moved up into the "above marginal" category. Thus social work has had some effect but it was restricted to those who were already functioning at "marginal" and "above marginal" levels before treatment.

The extent and type of improvement

If social work influenced social functioning, what intensity of intervention benefited what sort of families and in which areas?

To answer the first part of this question it is necessary to look at the movements made by families in the two treatment groups. The movements have to be considered in the context of the number of areas in which the families showed some movement. This analysis then has to be related to their functioning levels before and after social work.

In the "intensive" treatment group families moved upward by only one, two or three scale points. The following table indicates the pre-test and post-test levels of families that moved by these points.

Table 12. Upward movement by scale points in the "intensive" treatment group

Functioning level of families who moved by 1 scale point		Functioning level of families who moved by 2 scale points		Functioning level of families who moved by 3 scale points	
Pre-test	Post-test	Pre-test	Post-test	Pre-test	Post-test
4	5	4	6	1	4
4	5	4	6	3	6
5	6	4	6		
4	5	5	7		
5	6	4	6		
5	6	4	6		
5	6	4	6		
		5	7		
Total of Families:					
7	7	8	8	2	2

The table shows that a total of seventeen out of twenty-one families moved upwards. Of these seventeen, forty-one percent moved relatively little, by one scale point only. The thing to note is that eighteen percent of these were functioning at the "marginal" (scale point:4) level and twenty-three percent were functioning at the "above marginal" (scale point:5) level before intervention.

Eight families in this group (forty-seven percent) moved by two scale points. Of these thirty-five percent were functioning at "marginal" level (scale point:4) and twelve percent were functioning at the "above marginal" level (scale point:5).

Two families (twelve percent) moved up the scale by three points. Of these six percent were functioning at an "inadequate" level (scale point:1) while the other half were at the "below marginal" level (scale point:3).

The twelve percent that gained most from "intensive" treatment belonged to the "below marginal" category of functioning. Among the families that gained by one and two scale points fifty-three percent were functioning at the "marginal" level compared to thirty-five percent who were functioning at the "above marginal" level. Thus, sixty-five percent/families functioning at "marginal" /of and "below marginal" levels made more significant improvements than the twenty-five percent who started off in the "above marginal" category.

Let us now consider the movements made by the "less intensive" treatment group. In this group families that indicated movement did so by only one and two scale points. In this analysis we will also look at the pre-test functioning levels of the families that recorded no change.

Table 13. Upward movement by scale points in the "less intensive" treatment group

Functioning level of families who moved by 1 scale point		Functioning level of families who moved by 2 scale points		Functioning level of families who recorded no change	
Pre-test	Post-test	Pre-test	Post-test	Pre-test	Post-test
5	6	4	6	3	3
5	6	5	7	2	2
5	6			2	2
5	6			5	5
5	6			6	6
5	6			6	6
5	6			7	7
6	7			7	7
5	6				
5	6				
6	7				
Total No. of families					
11	11	2	2	8	8

The table shows that a total of thirteen of twenty-one families moved upwards. Of these eighty-five percent moved by one scale point, all of which were already functioning at the "above marginal" level before intervention. Of the two families who moved by two scale points, one was at the "marginal" level (scale point:4) while the other was "above marginal" (scale point:5).

Of the eight families that showed no change three (thirty-eight percent) were in the "below marginal" category before treatment and five were the "above marginal" category. The remaining twenty-six percent were already functioning at adequate levels.

The significance of this is that all families that gained from the "less intensive" type of treatment were families already functioning at "above marginal" levels before treatment with only one family functioning at a "marginal" level and rising by two scale points. However, the families that did not gain from this type of treatment were those functioning at "below marginal" levels and those functioning at "adequate" or "near adequate" levels.

In other words it seems that families functioning initially at "marginal" or "below marginal" levels gained most from "intensive" treatment and families functioning at "above marginal" levels responded to "less intensive" treatment. However, those families assessed as functioning at "below marginal" levels prior to intervention do not seem to have gained from the "less intensive" treatment approach.

Areas of functioning most affected by treatment

To find out which areas were most influenced by the different intensities of treatment, we have to look at the movement the families made within each specific area of family functioning. To reiterate the areas, they are:-

1. Block A - Social setting factors
2. Block B - Influence and support of social resource systems
3. Block C - Values and general planning
4. Block D - Knowledge, attitude and practice of family planning
5. Block E - Family organisation
6. Block F - Marital action system

Since few changes were observed in the control group they have been omitted here.

Table 14(i). Percentage of families functioning at different levels in Block A before and after treatment

Category of functioning	Intensive		Less Intensive	
	Pre-test %	Post-test %	Pre-test %	Post-test %
Below marginal	38	5	20	16
Marginal	11	10	23	8
Above marginal	51	85	57	76
Total	100	100	100	100

In Block A, the social factors included such things as income, budgeting, the circumstances of the children and spouses, and home management. In the "intensive" treatment group, those families functioning at "below marginal" levels were reduced from thirty-eight percent to five percent. The total in the "above marginal" category increased from fifty-one percent to eighty-five percent. In the "less intensive" treatment group the number in the "below marginal" group was reduced from twenty percent to ten percent. However, for those in the "marginal" category it was reduced from twenty-three percent to eight percent, thus increasing those in the "above marginal" category from fifty-seven to seventy-six percent.

In this area where the use of resource systems was concerned, the client group proved to be quite inadequate before treatment. In the "intensive" treatment group thirty-six percent were in the "below marginal" category, as were forty-eight percent of the "less intensive" treatment group. This decreased to five percent and eighteen percent respectively after treatment. Of the "marginal" category twenty-seven percent were reduced to fourteen percent after intensive treatment whereas twenty-three percent of "marginals"

became twenty-seven percent with "less intensive" treatment. However, the adequacy level in the "intensive" treatment group rose from thirty-seven to eighty-one percent, i.e. by forty-four percent whereas in the "less intensive" group the increase was only twenty-six percent.

Table 14(ii). Percentage of families functioning at different levels in Block B

Categories of functioning levels	Intensive		Less Intensive	
	Pre-test %	Post-test %	Pre-test %	Post-test %
Below marginal	36	5	48	18
Marginal	27	14	23	27
Above marginal	37	81	29	55
Total	100	100	100	100

Table 14(iii). Percentage of families functioning at different levels in Block C

Categories of functioning levels	Intensive		Less Intensive	
	Pre-test %	Post-test %	Pre-test %	Post-test %
Below marginal	38	5	24	16
Marginal	11	10	14	4
Above marginal	51	85	62	80
Total	100	100	100	100

In terms of block C relating to value systems and general planning forty-nine percent of the "intensive" treatment group functioned at the "marginal" and "below marginal" levels before treatment, whereas after treatment the percentage had decreased to fifteen in these categories, resulting in an increase in the "above marginal" category from fifty-one to eighty-five percent, a rise of thirty-four percent. However in the "less intensive" treatment group, the "above marginal" category increased by only eighteen percent.

Table 14(iv). Percentage of families functioning at different levels in Block D

Categories of functioning levels	Intensive		Less Intensive	
	Pre-test %	Post-test %	Pre-test %	Post-test %
Below marginal	29	-	28	10
Marginal	13	6	19	20
Above marginal	58	94	53	70
Total	100	100	100	100

Block D analyses changes in the areas of knowledge of attitude towards and use of family planning methods. Here again the "intensive" treatment group moved up more than "less intensive" treatment group. For example, of the twenty-nine percent in the "below marginal" "intensive" group some remained there after treatment and of the original thirteen percent in the "marginal" category only six percent remained after treatment. The increase in the "above marginal" category was therefore thirty-six percent.

In the "less intensive" treatment group the percentage in the "below marginal" level was reduced by eighteen percent and the "above marginal" level was increased by seventeen percent.

Table 14(v). Percentage of families functioning at different levels in Block E

Categories of functioning levels	Intensive		Less Intensive	
	Pre-test %	Post-test %	Pre-test %	Post-test %
Below marginal	10	5	19	19
Marginal	24	10	0	0
Above marginal	66	85	81	81
Total	100	100	100	100

In this area there were significant improvements among the "intensive" treatment group but not so with the "less intensive" treatment group. This area, which deals with inter-familial relationship, prohibitions, affectional ties within the family mobility, shows no movement at all using the "less intensive" treatment approach.

As regards the marital action system which also indicates the families' potentials and readiness to act on decisions, forty percent of the "intensive" group were in the "marginal" and "below marginal" categories before treatment whereas only nineteen percent remained in this category after treatment. However, in the "less intensive" treatment group there was no movement in these categories, although all those in the "marginal" category (ten percent) moved to the "above marginal" category after treatment.

Table 14(vi). Percentage of families functioning at different levels in Block F

Categories of functioning levels	Intensive		Less Intensive	
	Pre-test %	Post-test %	Pre-test %	Post-test %
Below marginal	25	19	20	20
Marginal	15	0	10	0
Above marginal	60	81	70	80
Total	100	100	100	100

Summary

There appears to have been little change in functioning levels as a result of re-housing above. However, the pre-test and post-test scores indicate an overall upward movement in terms of functioning scores after treatment. Those in the "intensive" treatment group showed more of an improvement than those in the "less intensive" treatment group. The control group's outcome shows no change except that one family regressed in functioning while two showed some improvement, although only as a result of some, albeit minimal, intervention.

Families functioning at "below marginal" levels prior to intervention responded more readily to "intensive" treatment than they did to the "less intensive" treatment approach. However, families already functioning at "above marginal" levels showed considerable improvement with the "less intensive" treatment approach.

All areas of social functioning showed significant improvement with "intensive" treatment. But in the "less intensive" treatment the areas relating to relationships, and affectional ties - in short family organisation - did not show any improvement and in the area of a family's acting potentials none in the "below marginal" category showed any improvement with this "less intensive" approach.

CHAPTER VIII

SUMMARY OF THE FINDINGS AND THEIR IMPLICATIONS FOR SOCIAL WORK PRACTICE

Summary

The study population comprised sixty-two families of Indian labourer origins in Singapore. This group, which had long lived in an inadequate social environment, was known to consist of "multi-problem" families. They were finally rehoused in a socially and physically more adequate environment that could be more conducive to social functioning.

This experiment set out to explore whether rehousing per se would improve their levels of functioning and if not whether social work intervention, introduced during this period of transition, would influence functioning levels. Furthermore, this experiment also tested the effects of different intensities of social work with the families in order to find out what type of families would respond to what sort of social work and in which areas of social functioning.

Towards this purpose a conceptual framework for studying family functioning was constructed and, as conventional long term casework was known to have had little effect on these families' functioning levels, a more focused but brief unitary social work approach was taken in working with the client population.

The study population was assessed in terms of functioning levels prior to, and again six months after, rehousing during which no social work intervention was implemented. The study population was then randomly allocated into one control and two treatment groups. The families were then reassessed using the same criteria after social work intervention.

The findings were that rehousing per se did not greatly improve functioning levels. Those families living in the larger flats reported that they felt rehousing had improved their physical living environment but had, in fact, increased their financial problems. For the other half of the study population who were rehoused into one-room flats, rehousing had, in fact, had very little effect upon their quality of life.

Rehousing, however, had contributed to placing more social resources closer to these people's doorsteps, it had certainly removed the "woebegone look" of their former quarters and the lable of a "ghetto".

In terms of specific areas of social functioning, rehousing alone had little or no effect. Social work intervention, however, did make a difference to functioning levels. In both treatment groups families showed themselves to have gained from social work intervention. This finding was in contrast to the little movement recorded in the control group.

The most significant result of this study, however, is that families functioning at "above marginal" levels before intervention seemed to have made adequate gains by the "less intensive" treatment method, but families functioning at "below marginal" levels showed no concrete movement when treated with this "less intensive" social work approach. On the other hand families functioning at "below marginal" levels seemed to have gained more from "intensive" treatment than those already functioning at "above marginal" levels prior to intervention.

Although "intensive" treatment seemed to have improved all areas of functioning, the "less intensive" treatment approach showed very little indication of having improved inter-familial relationships or the affectional ties within a family. Obviously this is an area of family functioning which, if seen as inadequate, will need more intensive treatment.

Some value based problems confronting an action research

An experiment in social work in itself implies various problems. An experiment in a laboratory for instance, allows for many variables to be controlled by the researcher. However, in an experiment with people in real situations the variables that are beyond control are numerous. Social science, however, has to explore and expand in spite of these obstacles.

In addition to the problem of controlling the research subjects, a study such as this further poses the problems of value judgments: an obstacle that could so easily deter social work research. The ensuing discussion considers some of the problems faced in this study.

To study family functioning and to define adequate and inadequate levels is by no means a simple task. Human behaviour in family situations is complex, and the interactional patterns and analysis of cause/effect behaviour are certainly not easy areas to study. The roles and responsibilities of a family are dictated or influenced by the normative patterns of individual cultures and communities. The levels of adequacy are also based on their respective value systems. Nevertheless, the process of social work intervention inevitably involves some sort of assessment of individual and group social functioning, and hence value judgments as to its adequacy or inadequacy.

Despite the social work profession's great hesitancy and sensitivity in making value judgments, decisions have to be made on clients' needs, the kinds of services or skills required to assist them, the timing of intervention and the withdrawal of support. Assessing client's functioning levels invariably means making judgments and judgments as a rule are based on values.

However, practitioners who work with specific types or groups of clients are usually familiar with the values and norms of that particular culture, as I was with my group of clients. Assessment of expectations, performance of roles and social tasks are thus within that culture's value system. It does not necessarily follow, therefore, that a social worker from a middle-class culture will base his or her assessment on the value base of his or her own culture. A professional will assess, for example, a client's functioning levels and needs on the basis of the expectations of the client's own community and cultural value system.

Although admittedly each culture or community will have its own value system and normative pattern of behaviour, it might nevertheless be true to say that there are similarities, for example, in the economic practices or the level of aspirations in the culture of the poor.

In some respects the profile of clients in this study when compared with that of, for example, the Mexicans in Oscar Lewis' "La Vida"[1] or with the Puerto Ricans in Hill, Stycos & Back's fertility study[2] or even with the American multi-problem families in the Family Centred Project of St. Paul's[3] show many commonalities in certain areas of social functioning. So when structuring a conceptual framework in order to study and measure family function in the Asian, or, as in this study, the Singaporean-Indian context, there is not necessarily a sound argument, theoretically, against using concepts established by studies of other communities. It may not be feasible to translate definitions or criteria uncritically or without a great deal of thought, but the conceptual framework with modified variables, or a combination of variables from more than one body of theory, can be applied.

I therefore felt that it was possible, in evolving the conceptual framework for family functioning used in this study, to draw heavily upon the two models used by Geismar and Hill respectively, despite their having been developed in another cultural setting.

The other prerequisite for this study was that social work intervention be quantified and implemented in different intensities. This was necessary to find out the effects of different intensities of treatment. To have to quantify the input variables of treatment is an unenviable task made more difficult by having to adhere to the stipulated "quantum" of input when working with people with "multiple problems". In such an experiment, conflicts and moral dilemmas, although predictable, were, I found, none the less painful. For example, the moral quandary of "not helping" when help was seen to be needed was felt from the start.

Indeed, I found this issue of value judgments and the denial of help one of the most difficult to deal with. Although I tried throughout to maintain my "objective" experimental stance, there was of necessity the odd occasion when I was forced to depart from it and offer help when it was against the stipulation of the experimental design.

Some implications for social work practice

It appears from this study that if social work help can be offered to a group at the opportune time (as in rehousing) the change and the re-adjustment period can be taken advantage of to modify old ingrained patterns of functioning. Rehousing can raise consciously or unconsciously the expectations of the people involved. Thus their receptiveness to change can be a distinct advantage that social workers can put to good use. The results in this study seem to indicate that this kind of intervention should be more constructively attempted with "multi-problem" families.

Secondly, the results of this study seem to reaffirm other already established findings, that brief and focused social work with "multi-problem" families can be as effective, or possibly more effective, than other types of intervention.

Furthermore, the results with two different intensities of treatment approach are encouraging enough to be considered seriously for practice. Families functioning at "below marginal" levels benefit most from the "intensive" treatment approach while families already functioning at "above marginal" levels do not need such intensive treatment. However, careful prior assessment of family functioning is necessary in order to decide which treatment approach to implement. This implies the need to have a structured but practicable method by which to assess family functioning.

The outcome in this study has indicated that rehousing per se did not improve the quality of life. Secondly, it has demonstrated that social work intervention did seem to help. The results have further shown that treatment need not necessarily be long and intensive for all clients; a less intensive but brief and focused treatment approach can be sufficient for the needs of some people.

I feel that it is necessary to examine more critically our conventional methods of intervention which, in my experience in Singapore at least, tend to be long drawn out and not clearly focused. Opportune times such as the initial period of rehousing should be more effectively used to change established patterns of behaviour, opportunities that might otherwise be lost. No society, however affluent, can, I maintain, afford to offer conventional help that is intensive, effective and unlimited. Offering help selectively in terms of intensity should surely be considered towards a better use of scarce social work manpower, expertise and professional time. This incorporated into a brief and focused approach might also help the effectiveness of social work if families' functioning levels can be carefully assessed prior to treatment, using a model of family functioning, such as the one described in this study, to determine which types of families or what areas of functioning need the "intensive" treatment method. This would also help to determine which families can afford to be treated with the "less intensive" treatment method.

This study does not claim to be conclusive. There surely must be aspects of this study that need further testing and validating. However, I hope that the findings in this study will at least stimulate further inquiries and experiments in treatment approaches in the Asian context.

References

1. O. Lewis, La Vida; a Puerto Rican family in the culture of poverty - San Juan and New York. (New York 1966).

2. R. Hill, M. Stycos and K. Back, 1959.

3. L.L. Geismar, 1960.

BIBLIOGRAPHY

ARASARETNAM, S., Indians in Malaysia and Singapore, (Bombay, Kuala Lumpur 1976).

BLENKER, M., "Obstacles to Evaluative Research in Casework" Social Casework, Vol. 31, March (1950).

BALLARD, R.G. & Mudd, E.H., "Some Theoretical & Practical Problems in Evaluating Effectiveness of Counselling" Social Casework, Vol. 38, December, 1957.

BROWN, G., The Multi-Problem Dilemma: A Social Research Demonstration with Multi-Problem Families (1968).

Census of India 1931, Vol. XIV, Madras, Part 1, (Madras 1932).

DAVIES, M., "The Current Status of Social Work Research" British Journal of Social Work, 4, 3 (1974)

FISCHER, J., "Is Casework Effective? A Review" Social Work (U.S.A. 1973).

GEOGHEYAN, J., Emigration from India (Calcutta 1873).

GOPINATHAN, P., Towards an Understanding of Family Planning Behaviour, (unpublished dissertation, Singapore 1974).

GEISMAR, L.L., "Implications of a family Life Improvement Project" Social Casework, 52, July (1971).

GEISMAR, L.L., & Ayres B., Measuring Family Functioning (Minnesota, 1960).

GOTTSHALK, A., "Prediction and Evaluation of Outcome in an Emergency Brief Psychotheraphy Clinic" The Journal of Nervous and Mental Disease, Vol. 144, February (1967).

GOLDBERG, E.M., Evaluating the Success of Social Work. (Assn. of Directors of Social Services Study Conference 1972).

_____ Helping the Aged (London 1970).

GOLDSTEIN, H.K., Research Standards & Methods for Social Workers. (Illinois, 1969).

HILL, R., Stycos, M., Back, K., The Family and Population Control, (Chapel Hill, 1959).

HERZOG, E., Some Guide Lines for Evaluative Research (Washington 1959).

HUNT, J., & Kogan C., Measuring the Results in Social Casework. (New York, 1956).

HORST P. & Others, "The Prediction of Personal Adjustment", Bulletin of the Social Science Research Council, No. 48, (New York 1941).

KADUSHIN, A., "The Decline in Enrollment in Professional Schools" Social Casework, Vol. 38, January (1957).

KLONG Toy, A Social Work Survey of a Squatter Slum, Thammaset University (Bangkok).

LEWIS, O., La Vida; a Puerto Rican Family in the Culture of Poverty - San Juan & New York (New York 1966).

MAHAJANI, U., The Role of Indian Minorities in Burma and Malaya (Bombay, 1960).

MYRDAL, G., Objectivity in Social Research (London 1970).

MORRIS, H.S., Indians in Uganda (London 1968).

MEYER, H., Borgatta E., Jones, W., Girls at Vocational High: An Experiment in Social Work Intervention (New York 1965).

MURRAY, H.A., Explorations in Personality (New York 1938).

MOSER, C.A., Surrey Methods in Social Investigation (Heinmann 1967).

NAYAGAM, F., Little India (unpublished) dissertation, Singapore 1976.

NAGEL, E., Methodological Issues in Psychoanalytic Theory" Psychoanalysis, Scientific Method & Philosophy (New York 1959).

OTTEINGER, K.B. (ed.), Social Work In Action (New York 1975).

PINCUS A. & Minahan, A., Social Work Practice: Model & Method (New York 1973).

POWERS, Edwin & Witmer, An Experiment In The Prevention of Delinquency, The Cambridge Sommerville Youth Study (New York 1951).

PHILLIP, A.E., McCulloch, W., Smith, N., Social Work Research And The Analysis of Social Data (Oxford 1975).

PLOWMAN, A.E., G., What are the Outcomes of Casework (1967).

REID, W.J. & Shyne, A.W., Brief and Extended Casework (New York 1969).

REID, W.J. & Epstein L., Task Centred Practice (Columbia 1977).

_____ Task Centred Casework (New York, 1972).

ROSENBLATT, A., "The Practitioner's Use and Evaluation of Research". Social Work (U.S.A.) 13: January (1968).

SANDHU, K.S., Indians in Malaya, Immigration and Settlement 1786-1957 (Cambridge 1969).

SPECT, H., & Vickery, A., Integrating Social Work Methods (London 1977).

Report of the Committee on Local Authority and Allied Personal Social Services Series (London 1972).

SELLITIZ, C., Jahoda, H., Deutch, M., Cook, S., Research Methods in Social Relations (Methuen 1965).

STACEY, M., Methods of Social Research (1967).

TINKER, H., The Banyan Tree (Oxford 1977).

TRIPODI, T., Social Programme Evaluation: Guidelines for Health, Education and Welfare Administrations. (1971)

TIMMS, N., & Mayer, J., The Client Speaks; Working Class Impressions of Casework (1970).

THOMPSON, S., & Khan, J.H., The Group Process As A Helping Technique (Oxford 1970).

VINTER, R.D., "Essential Components of Group Work Practice" Readings in Group Work Practice (Michigan 1967).

VAITHIALINGAM, D.K. (ed.), "Family Planning and Family Organisation" Social Work Department, Singapore University Series(Singapore 1975).

WINSTEDT, R.O., "Indian Influence in the Malay World" Journal of the Royal Asiatic Society of Great Britain (London 1944).

WOLBERG, L.R. (ed.), Short Term Psychotheraphy (New York 1965).

WEISS, C., Evaluative Research: Methods for Assessing Programme Effectiveness (1972)

APPENDIX I

INTERVIEW SCHEDULE

Notes to the administration of the interview schedule

The interview schedule was only semi-structured. This was to facilitate the flow of data collection. The information gained through this interview schedule was not necessarily in the stipulated order as in the schedule. Some of the questions had to wait to be asked when the opportune time arose.

The information thus was not collected in one interview but through several as the relationship proceeded. This was necessary as some of the questions asked were of an intimate nature and thus rapport had to be established first.

As all interviews were conducted in Tamil, the English translations of the questions asked merely represent the area of inquiry and not necessarily the exact phraseology.

Schedule No.	
Address:	No.
Street:	Blk.
Name:	
Flat Type:	Rent
Case File No:	Group

Dietary Pattern and Home Organisation

Rice - Katis per month -

Rice - Price per kati -

Sugar - Katis per month -

Sugar - Price per kati -

Condensed Milk - tins per month -

Condensed Milk - price per tin -

Coffee _____

_____

Children's breakfast _____

_____

Usual Main Meal _____

_____

Sunday Main Meal _____

_____

Types of Fish Purchased _____

_____

Types of Vegetables Purchased _____

_____

_____

Observations on:

(a) Cleanliness

(b) Organisation of Space

(c) Attention family pays to creating privacy

(d) Decoration of the home

(e) Other

Monthly Income & Expenditure		
Rental Monthly Income		
Item	Amount	Further Details
1. Rent/Instalment		
2. PUB Bills		
3. Payments for H/P		
4. Household Head's Transport		
5. Spouse's Transport		
6. Household Head's Allowance		
7. Spouse's Allowance		
8. Total Food Bills		
9. Dependent's Total Exp.		
10. Entertainment		
11. Status Exp.		
12. Miscellaneous		
Total Expenses		
Savings/Debts/Pawn Tickets		

Modern Amenities	
1. Television	
2. Radio/Record Player	
3. Refrigerator	
4. Iron	
5. Fan	
6. Stove	
7. Luxury Table Ware	

Space for further details relating to:

(a) debts

(b) hire purchase

(c) expenditure patterns

General

(d) impression of family's ability to cope with money matters

	DATA	HUSBAND	WIFE
1.	Name		
2.	Date of Birth		
3.	Age		
4.	Religion		
5.	Country of Birth		
6.	Length of Residence in Singapore		
7.	Citizenship Status		
8.	Marital Status		
9.	Age at Marriage		
10.	Education Level		
11.	Education Stream		
12.	Country where Educated		
13.	Language of Interview		
14.	Occupation		
15.	Income per Month		
16.	Years of Service		
17.	Employer		
18.	Employment History		
19.	Secondary Occupation		
20.	Income per Month		
21.	Total Income per Month		
22.	Father's Country of Birth		
23.	Mother's Country of Birth		
24.	Father's Citizenship		
25.	Mother's Citizenship		
26.	Father's Country of Residence		
27.	Mother's Country of Residence		
	Residence Since Marriage	Space for further details	

Household Members - Adults

	Name	Yr. of Birth	Place of Birth	Citizenship Status	Age	Sex	Relationship to Hse. Head	Marital Status	Job	Income p/m	Contribution p/m	Education Level	Education Level
1.													
2.													
3.													
4.													
5.													
6.													

Space for further details

a) Criminal Records:

b) Health:

c) Special Needs:

d) Other:

I.(v)

Household Members - Children

	Name	Year of Birth	Place of Birth	Citizenship Status	Age	Sex	Relation-ship to Hse. Head	Edun. Level	Edun. Stream AM/PM	Name of School	Fees	Pocket Money p/m	Tranport p/m	Other Mthly Exp.
1.														
2.														
3.														
4.														
5.														
6.														

Space for further details

Books for 1975

Uniform/Shoes 1975

Ave. Total monthly expense for all children

a) Criminal record:

b) Health:

c) Special needs;

d) Other:

1. Would you tell me how different your former neighbourhood is to the present?

2. What do you think about your present home?

3. Have you changed your market, grocer and clinic from your former neighbourhood to the present?

4. What are your reasons for this?

5. If you have a problem or if you have to decide on something, like a quarrel in your family or making a major purchase, do you discuss it with anyone outside your family?

6. Who do you often talk about these matters with and why have you chosen them?

7. Do you find that what they usually advise is what most people in your station of life would do?

8. If there was a sudden and grave illness in your family or if there was a financial crisis who would you turn to for help?

9. Was your marriage arranged and if so by whom, otherwise how did you get married? Did you have much say in it?

10. In general how do you feel about your marriage?

11. Why do you say that?

12. How would you describe your intimate relationship with your spouse?

13. (Prompt for further clarification)

14. How are most decisions arrived at?

15. Are both of you aware of the problems in the family, for instance if the children are not doing very well or if there is a problem in making ends meet?

16. Are matters such as finance, children etc. discussed between you both?

17. If there is a disagreement in the family who has the final say?

18. Are you happy with your present number of children?

19. Do you think that having children is the most important thing in life?

20. What do you think is an ideal family size?

21. Are you using any contraceptive method now? What type and how long have you been using it? What do you think of it? If you are not, are there some reasons for it?

22. Have you tried or know any other method? Could you give some examples? If you have not tried or don't know, could you tell me why?

23. Do you discuss such matters as contraceptives and sexual relations with your husband?

24. What do you feel about doing this?

25. Would you discuss it with your doctor/nurse?

26. Could you give me your reasons for it?

27. Are you satisfied with your children's progress in general? If not why and in which areas?

28. Are there any major areas of discord with any of your adult children - if so how did this come about?

29. Has any child ever got into trouble with the law?

30. If so who did you see about this and if you didn't - was there a reason for not doing so?

31. If no, are you anxious that they might get into trouble? What makes you say this?

32. Do the children get along with each other? If not what caused this?

33. Who does the disciplining of children?

34. In order to get on in life, what do you think is more important - to work or to be lucky?

35. Can you tell me why you believe this to be so?

36. Would you say a child should follow in his father's footsteps or make his own life?

37. (Prompt for reasons)

38. Should girls be given equal opportunity to education?

39. Should women go out to work if they can and do you think they only should before or after marriage or this should have no bearing?

40. In general, would you say it is better to make plans for most things or is it better to leave them to fate?

41. (Prompt for reasons)

42. In general, are you satisfied with your way of life?

43. Would you say that your way of life is better, same or worse than it was five years ago? In what ways?

44. Do you think moving house has any bearing on it? In what ways?

45. Is there a kind of pattern whereby father does some things, mother some and children others?

46. If so, was this pattern consciously inculcated?

47. (Prompt for clarification)

48. Are there things that are not allowed to be done by the family members?

APPENDIX II

DATA COLLECTION FORMAT

File No:

Score Sheet

The Scale

Adequate	7	High
Near Adequate	6	High
Above Marginal	5	High
Marginal	4	Middle
Below Marginal	3	Low
Near Inadequate	2	Low
Inadequate	1	Low

Block Score

Block	Score						
A	1	2	3	4	5	6	7
B	1	2	3	4	5	6	7
C	1	2	3	4	5	6	7
D	1	2	3	4	5	6	7
E	1	2	3	4	5	6	7
F	1	2	3	4	5	6	7

Judge's Name

Composite Score

Block A

	Age	Religion	Education	Citizenship	Occupation
Man					
Woman					

Source of data: Data sheet in interview schedule on spouses.

Children	Total No.	Males -	Females -
	No. in school		
	Type of school		
	Ages		
	Schooling level		
	No. working		
	Ages		
	Schooling level		
	Others		
	Ages		
	Circumstances		
	Schooling level		

Sources of data: Data sheet in interview schedule on children

Comment:

Finance	Monthly Income	Monthly Expenses	Savings	Debts
Comment				

Source of data: Income and Expenditure sheet in Interview Schedule

File No:

Block A

Flat Type	1 room 3 room 4 room 5 room
Status	Rented Purchased
Modern Amenities	T.V., Radio, Frig., Iron, Fan, Gas/Electric Stove
Upkeep of Flat	
Reaction to Resettlement	

Source of data: Data sheet on Home Organisation in interview schedule and questions No. 1 & 2.

Block B

Influence and Support of Friends, Kin and Environment

Source of data: Question Nos. 5, 6, 7, 8, 44

Block C

Traditionalism, Fatalism, Aspiration for self/children, General Planning

Source of data: Questions Nos. 3, 4, 9, 27, 29, 30, 31, 34, 35, 36, 37, 40, 41, 42, 43

File No:

Block D

Importance of children, Ideal family size, Knowledge of F.P., Use and attitude

Source of data: Questions Nos. 18, 19, 20, 21, 22, 25, 26

Block E

Power structure, Affectional ties, Role allocation, Prohibition

Source of data: Question Nos. 10, 14, 17, 28, 33, 45, 46, 47, 48

Block F

Marital communication, Marital consensus, Sexual satisfaction

Source of data: Questions Nos. 10, 11, 12, 13, 15, 16, 23, 24

Points to Note

APPENDIX III

CRITERIA FOR MEASUREMENT

BY

L.L. GEISMAR & AYRES

A. Family Relationships and Family Unity

1. Marital Relationship

Marital relationship should be checked where either or both of the following are applicable: 1) one partner has a legal responsibility towards the other; 2) there is a continuing extra-marital relationship of significance in family functioning.

Check not applicable where the above are not present.

Inadequate	Marginal	Adequate
Separate partner does not support when so ordered, or is extremely disturbing influence on family.	Separated partner does not support adequately or regularly or is a disturbing influence in family.	Couple lives together.
Extra-marital relations endangering children's welfare, or have come to attention of law.	Extra-marital relations exist but do not openly affect welfare of children.	Extra-marital relations, if present at all, are minimal and transitory and have not been allowed to jeopardise family solidarity.
Emotional tie so deficient that children endangered.	Weak emotional tie between partner, lack of concern for each other.	Positive emotional tie between partners who can express need for the other's help and respond appropriately to need. Considerable pleasure derived from shared experiences.

Inadequate	Marginal	Adequate
Severe, persistent marital conflict necessitating intervention by authorities or threatening complete disruption of family life.	There are some points of agreement between parents, but disagreement and conflict tend to predominate & obscure them.	Consistent effort to limit scope and duration of marital conflict and keep communication open for resolution of conflicts which arise.

2. Parent-Child Relationship

No affection shown between parents and children. Great indifference or marked rejection of children. No respect shown for one another. No approval, recognition on encouragement shown to children. If any concern shown at all by parents, it takes the form of rank discrimination in favour of a few against the rest. Parent-child conflict extremely severe. (Above so serious as to constitute neglect as legally defined and warrant intervention by authorities).	Affection between parents and children intermittent, or weak, or obscured by conflict. Parents' anger unpredictable and unrealated to specific conduct of children. Family members played off against each other. Marked favouritism with no attempt to compensate disadvantaged children. Little mutual respect or concern for each other. Parents and children frequently in conflict. (Above present, but danger to children is potential - not actual).	Affection shown between parents and children. Parents try always to be consistent in treatment of children. Children have sense of belonging, emotional security. Children and parents show respect for each other, mutual concern. Parent-child conflict is minimal or restricted by consistent attention. Free communication, and desire for harmony.

3. Relationships Among Children

Inadequate	Marginal	Adequate
Conflict between children resulting in physical violence or cruelty which warrants intervention.	Emotional ties among children weak. rarely play together. Fighting occurs often, teasing, bullying, other emotional or physical cruelty. Children rarely share playthings, show little loyalty to one another or pride in other's achievements.	Positive emotional ties and mutual identification among children. Depending on age, often play together, share their playthings. Loyal to each other, enjoy other's company, take pride in achievements of other siblings. Fighting and bickering normal for age.

4. Family Solidarity

Inadequate	Marginal	Adequate
Marked lack of affection and emotional ties among family members. Conflict among members persistent or severe.	Little emotional warmth evidenced among family members. Family members often in conflict.	Warmth and affection shown among family members, giving them a sense of belonging and emotional security. Conflict within family dealt with quickly and appropriately.
Marked lack of cohesiveness and mutual concern, satisfactions in family living not evident. No pride in family or sense family identity. Members plan on basis personal gratification rather than family as whole. Serious danger family disruption. (Above so serious that laws relating to neglect or cruelty violated or family welfare so threatened that intervention justified).	Little cohesiveness, such as members rarely do things together, eat together; little planning towards common family goals; little feeling of collective responsibility; little pulling together in crisis. Few satisfactions in family living. (Above present potential but not yet actual danger to welfare of children).	Definite evidence of cohesiveness, such as: members often do things, together; eat together; family plans and works towards some common goals; definite feeling of collective responsibility; members pull together in times of stress. Members find considerable satisfaction in family living.

B. Individual Behaviour and Adjustment

1. Individual Behaviour of Parents

Check separately for mother and father. Check "not applicable" if parent has no tie to family, as indicated under marital relationship. If there are more than one mother or father figures with ties to family, check the one who has the strongest tie with the family. Check "inadequate" if consequences of law violations (incarceration, probation, etc.) are still operative.

Inadequate	Marginal	Adequate
Socially Delinquent Behaviour: Is incarcerated or on probation for law violation. Seriously deviant sexual behaviour (Promiscuity etc.) or serious offences against family (assault, incest, etc.) endangering welfare of children. Excessive drinking severely affecting family welfare (reducing budget below minimal level, causing severe conflict, etc.) and warranting intervention for sake of children.	**Socially Delinquent Behaviour:** Minor law violations not resulting in incarceration or probation, deviant sexual conduct, offences against family, or excessive drinking, but not seriously affecting family welfare. Deficiency in social skills which handicaps comfortable relationships to people and institutions.	**Socially Delinquent Behaviour:** Law violations limited to such slight infractions as minor traffic violations. Drinking or extra-marital relations not a serious problem to individual or to family. Has fair complement social skills, relates comfortably to most people and institutions.
Mental - Physical State: serious mental illness requiring intervention or resulting in institutionalization.	**Mental - Physical State:** Mental or emotional disorder present but able to function on minimal level, not actually dangerous to family.	**Mental - Physical State:** Mental health good.

Inadequate	Marginal	Adequate
Metal - Physical State:	Mental - Physical State:	Mental - Physical State:
Metal defectiveness requiring institutionalisation or so limiting capacity to maintain family life that special help or training necessary.	Mental retardation seriously limiting functioning.	Performs up to mental capacity and able to function adequately in most areas.
Parent has disease which endangers public health, has not sought or caried through on treatment, health authorities have right intervene, chronic or major physical disease orhandicap so disabling that person unble to provide the minimum care for children who are his major respasibility.	Chronic or major physical disease of handicap which is somewhat disabling, but permits minimal functioning especially in regard to care of children.	Diseases or handicaps not of serious nature, receiving appropriate treatment, functioning hampered only slightly if at all.
Role Performance:[1]	Role Performance:[1]	Role Performance:[1]
As Spouse: If deserted or separated, does not support when soordered. Extra-marital liaisons endangering family. Severe conflict with spouse damaging to children.	As Spouse: Frequent conflict or disagreement with spouse in many areas of living, emotional tie weak.	As Spouse: Conflict with spouse minimal, dealt with appropriately; extra-marital affairs rare, positive emotional tie, disagreements well handled or well tolerated.
As Parent: Violation of laws relating to neglect of children, assault, incest, etc. making intervention necessary.	As Parent: Little concern for or interest in children. Displays little affection for them, physical and emotional care provided minimal.	As Parent: Positive relationship with children, shows them affection, spends time with them, provides appropriate physical and emotional care.

Inadequate	Marginal	Adequate
Role Performance:	Role Performance:	Role Performance:
As Breadwinner: If absent, does not support when so ordered. If at home, and physically able to work, is unable or unwilling to support family.	As Breadwinner: Provides marginal or uncertain income, but little or no PA required. (Unless so disabled as to require outside support).	As Breadwinner: Provides income for family enabling above minimum living standard. Works regularly at full time job. Has positive feeling for job.
As Homemaker: Housekeeping and care of children so inadequate that it constitutes neglect and warrants intervention.	As Homemaker: Housekeeping and care of children poor, but health of family not seriously endangered.	As Homemaker: Housekeeping and care of children is generally good.
As Member of Community: Law violations other than offences against family. Extremely hostile attitude towards community-children encouraged to commit anti-social acts.	As Member of Community: Has little or no social contacts with neighbours, relatives, etc. belongs to no social groups, is dissatisfied with social status. Has a generally hostile attitude towards community, makes poor use of resources, does not participate in groups having a civic purpose. (As PTA, Scouts, Chest Drives, etc.)	As Member of Community: Has meaningful ties with friends, relatives, etc. belongs to social groups or clubs which provide satisfaction, is comfortable with social status, with or without some desire to improve it. Has positive attitude towards community, makes good use of facilities when necessary, lends some support to community betterment.

2. Individual Behaviour and Adustment of Children

For purposes of scoring, children 10 and over are considered together, as are children from 1-9. The total score for each group is determined by finding the average of separate scores. Do not consider children who are permanently out of home.

[1]Due allowance should be made for variations in parental roles made necessary by the particular family structure. Thus the mother's role as supplementary or chief wage earner needs to be considered where children do not have to be looked after during the day. The father's role as homemaker may have to be reviewed where he is unable to earn a living, etc.

Inadequate	Marginal	Adequate
Acting Out Behaviour:	Acting Out Behaviour:	Acting Out Behaviour:
Acting out, disruptive, anti-social behaviour of serious concern and indicative of a child in real danger, warranting intervention, incarcerated or on probation.	Acting out, disruptive, anti-social behaviour of less serious nature, not a long standing pattern not indicative of more serious problems, therefore intervention not warranted.	Acting out behaviour is normal for age - pranks, mischievousness, etc., not of serious nature.
Mental - Physical State: Mental illness requiring intervention or resulting in hospitalisation. Excessively withdrawn or other behaviour suggesting emotional disturbance or serious problems in relating to others.	Mental - Physical State: Emotional disorder evident, but receiving treatment or not serious enough to justify intervention.	Mental - Physical State: Emotional health appears good, enjoys appropriate activities, relates well to others.
Mental defectiveness requiring institutional training or custodial care that parents are unwilling or unable to provide.	Mental retardation severely limiting functioning, but special training, such as special class received.	Performs up to mental capacity and able to function adequately in most cases.
Child has disease which endangers public health, no measures taken for isolation or treatment. Other serious health conditions or handicaps for which parents neglect or refuse to provide proper care.	Child not retarded, but performs well below capacity. Presence of chronic or major physical disease or handicap receiving some treatment, but permits minimal functioning.	Diseases or handicaps if present are receiving appropriate care with resulting favourable adjustment.

Inadequate	Marginal	Adequate
Role Performance:	Role Performance:	Role Performance:
As Child: Violent destructive, or assaultive behaviour against family members.	As Child: Gets along poorly with parents and siblings, rarely performs household duties.	As Child: Close ties to family members. Continuous participation in household duties and family life.
As Pupil: Excessive truancy, disruptiveness, incorrigibility, property destruction causing intervention. Other infringements of school regulations resulting in suspension, expulsion, etc.	As Pupil: Acting out or withdrawn behaviour of less serious nature. Attendance not regular but no action taken. School work poor. Little positive feeling towards school.	As Pupil: Attends regularly, school work apporximates ability, positive attitude towards school. Acting out limited to occasional pranks.
As Member of Peer Groups: Participation with others in delinquent acts. So unable to relate to peers as to be severely emotionally disturbed. Often involved in severe conflicts with peers.	As Member of Peer Groups: Has few friends, belongs to no peer groups, conflict with peer common.	As Member of Peer Groups: Is well liked, has friends, belongs to one or more peer groups.
	C. Care and Training of Children	
	1. Physical Care	
Supply and care of clothes, cleanliness, diet, and health care provided for children seriously endangers their health or threatens adjustment at school and acceptance in peer groups. Vermin a serious health or social handicap.	Children have few clothes, which are dirty and not mended, pay little attention to cleanliness receive unbalanced, unnutritious diet, parents lax in looking after health needs of children, but health of children and social adjustment are not threatened to the extent that intervention is justified.	Children have suitable clothes are kept clean, diet well balanced and wholesome, health needs looked after promptly.

2. Training Methods and Emotional Care

Inadequate	Marginal	Adequate
Affection rarely shown to children, marked indifference or obvious rejection. Parents have pathological tie to children, use them as pawns. Physical and emotional cruelty. (Above so serious that intervention warranted).	Little affection shown to children, parents usually indifferent to or reject children, or are often permissive. Children have little sense of emotional security. (Above potential rather than actual danger to children).	Parents show steady affection for children, provide atmosphere of emotional warmth, sense of belonging.
Parents' behaviour standards so deviant from wider community that children encouraged towards anti-social acts.	Parents' behaviour standards in many respects somewhat deviant from community, or there is a lack of standards, or parents expect too much or too little maturity.	Parents' ideas of how children should behave are generally those acceptable to community. Standards of behaviour are appropriate to age level.
Physical punishment overly severe, or inappropriate. Extreme lack of discipline. Inconsistency of method in one parent or between parents, limits not enforced, strong disagreement between parents on training. Approval shown rarely or not at all. (Above directly contributes to delinquent behaviour or otherwise puts children in danger).	Parents overly rigid, overpermissive, indifferent. Physical punishment, searing occurs. Discipline not appropriate to behaviour. Approval of good conduct rare. Parents are inconsistent, often do not enforce limits, disagree with each other over exercise of discipline, do not share task of training. (Above potential rather than actual danger).	Parents neither overly rigid nor overpermissive. Physical punishment rare. Method used usually appropriate to behaviour. Approval of good conduct often shown. Parents are fairly consistent in exercising discipline, enforce limits set, agree with each other in exercising discipline, share job of training children.

D. Social Activities

1. Informal Associations

Inadequate	Marginal	Adequate
Conflict with relatives, neighbours, friends resulting in physical violence or illegal activities. Persons as above such a disturbing and discordant influence on family as to endanger welfare of children. Participation with friends in perpetrating delinquent or anti-social acts.	Broken, discordant, indifferent relationships to relatives frequent squabbles with neighbours. Family members have few or no social outlets with friends or have friends whose influence leads to dubious social consequences (drunken sprees, destruction of property, children left alone, etc.).	Majority of relationships with relatives are pleasant and satisfying. Fairly amicable relationships maintained with neighbours. Family members have social outlets with friends providing recreational and interpersonal satisfactions, sense of identification with larger groups, provide necessary socialization experiences for children.

2. Formal Associations

Membership informal groups perpetrating anti-social acts. Behaviour in organized group so destructive or disruptive that intervention necessary.	Family members belong to no organized groups. No activity with groups having a civic orientation. Family feels socially rejected and unable to improve social status.	Family members, where appropriate, belong to some clubs, organizations, union, etc., some members active in groups which lend support to community betterment.

E. Economic Practices

1. Source and Amount of Income

Inadequate	Marginal	Adequate
Income entirely from general relief because of failure of able bodied head of household to support. (Except temporary layoffs, and ADC or other payments due to absence of husband or his disability). Income from PA obtained through fraudulent means. Income derived from theft, forgery, etc.	Income derived partly from general relief because head of household unable to hold a steady job or laid off because of employment situation, unless disabled because of physical handicap, mental illness or deficiency. Children of working age who are not in school, service, etc., are not working.	Income derived from work of family members, or from sources such as pensions, rents, support payments, etc., but money is not from public funds (except for pensions, A.D.C., A.B., O.A.A.)
Amount of income so low or unstable that basic necessities not provided for children.	Amount of income marginal or unstable, barely meets family needs.	Family sufficiently independent financially to afford a few luxuries of savings, is fairly well satisfied with economic status, and working toward greater financial security.

2. Job Situation

Behaviour on job breaks the law, as fraud, embezzlement, robbery, physical violence to co-workers.	Frequent changes of job, unsteady work pattern, works less than full time, job is below capability. Poor relations with boss and co-workers, dissatisfied with job.	Works regularly at full time job, seeks advancement, changes jobs only when unavoidable due to economic or other circumstances or for improvement. Job is suitable for person's capabilities, maintains harmonious relations with boss and co-workers, has positive feeling towards job.

Note: Above applies only to family members contributing substantially to support of family.

3. Use of Money

Inadequate	Marginal	Adequate
Severe conflict over control of income endangering children's welfare. Budgetting and money management so poor that basic necessities not provided. Excessive debt resulting in garnishment, or reduces family budget as above.	Disagreement over control of income leading to conflict among family members. Family unable to live within budget, money management poor, luxuries take precedence over basic necessities, impulsive spending. (Above not seriously endangering children's welfare).	Money spent on basis of agreement that such is responsibility of one or more members of family. Family budgets income, money management carried out with realistic regard to basic necessities. Debts are relatively few, and seldom incurred for luxuries; they are manageable and planned for in budget.

F. Household Practices

1. Physical Facilities

Property so deteriorated, kept in such poor state of repair. Facilities for sleeping, washing, sanitation, heat, water, refrigeration, or cooking so inadequate as to be an actual threat to the physical and emotional welfare of family members, particularly children, and necessitates intervention by health or other authorities.	Property deteriorated, in poor state of repair, sufficient space not available. Absence or inadequacy of basic household equipment. (Above potentially harmful to welfare of children).	Property kept in good condition, sufficient space for family members. Necessary household equipment available and in good working order.

2. Housekeeping Standards

Inadequate	Marginal	Adequate
Home maintained in such a dirty and unsanitary condition, meals so irregular, diet so inadequate as to constitute an actual hazard to physical well being of children. Vermin or rats present serious health hazard.	Home in disorder, meals irregular, diet poorly planned, making a potential hazard to physical welfare of children.	Home maintained in a condition conducive to good health, hygiene and a sense of orderliness. Meals served regularly, diet is well balanced and nutritious. Attention paid to making home attractive.

G. Health Conditions and Practices

1. Health Problems

Presence of communicable disease endangering public health, not isolated or properly treated. Major or chronic disease or handicap so severely limiting person's functioning within and without the home that there is an actual threat to family welfare, particularly the care children are receiving.	Presence of disease, major or chronic illness or handicaps which limits person's functioning inside and outside home, but constitutes no actual threat to family welfare.	Physical health of family members is such that they are able to function adequately in their various roles.

Note: Mental illness is not to be considered here, but is evaluated under individual behaviour and adjustment.

2. Health Practices

Inadequate	Marginal	Adequate
Proper treatment or quarantine not secured for diseases endangering life of person and/or public health. Parents neglect or refuse to provide medical or other remedial care for health and well being of children. Disease prevention practices (sanitation, diet, etc.) not followed conditions so poor that physical neglect of children is involved.	Refusal or failure to get or continue medical care other than in column to left. Medical instructions disregarded or not followed consistently. Disease prevention practices not generally followed, but health of children not seriously endangered.	Concern shown about ill health or handicaps, medical care promptly sought when needed, medical instructions followed. Disease prevention practices are observed.

H. Relationship to Family Centred Worker

1. Attitude Towards Worker

Physical violence of verbal assault and other types of insulting behaviour.	Worker met with hostility, resentment, of defensiveness on part of family or marked indifference shown.	Worker received with friendliness and readiness to consider family problems in relation to services offered.

2. Use of Worker

Refusal to talk with worker when the basis of community concern is such that the worker has a right to stay in the situation. Absolute refusal to acknowledge any problems.	Apathy apparently in dealing with caseworker. Reluctance shown to recognize and/or deal with major family problems.[1]	Willingness shown to work together with worker on major problems facing the family. Awareness shown of the major problems upon which casework has been concentrating and effort made to work toward solution of problem.[1]

1. Applicable mainly to functions after beginning situation.

I. Use of Community Resources

1. School

Inadequate	Marginal	Adequate
Parents extremely hostile to school, encourage or abet consistent truancy; are antagonistic to school personnel, refuse co-operation when this is necessary due to seriousness of community concern.	Parents place little value on education, take little interest in children's school activities, are lax in enforcing attendance, rarely have voluntary contact with school personnel, are uncooperative with school in plans for children, never participate in school activities like PTA, etc.	Parents value education for their children, see they attend school regularly, keep in fairly close contact with school personnel, are co-operative with them in working on joint plans for benefit of children, attend groups such as PTA.
Children have extremely negative attitude towards school, are excessively truant without excuse, are very disruptive, destroy school property, commit other infringements of school regulations demanding intervention.	Children have negative attitude towards school, truant rather frequently, are disruptive or a disturbing influence, do poor school work, but not sufficiently serious to warrant intervention.	Children like school, attend regularly, are not behaviour problems, achieve according to capacity.

2. Church

Note: Check under "Marginal" and "Adequate" only if family member(s) are active members of a church or church group. If there are no church ties, or only nominal church membership, check "not applicable". "Inadequate" applies whether or not there are church ties.

Inadequate	Marginal	Adequate
Law violations directed against church, as robbery, destruction of property, committing nuisances, vandalism, etc. instilling hostile attitudes in children towards religion of others.	Using church for purposes sharply at variance with aims of church, as being an extremely disruptive influence in a church group. Parents prevent participation of children in any church activities. Permitting children to attend Sunday school or church social activities but parents oppose or show negative attitudes towards church.	Attend church fairly regularly derive personal satisfaction from church tie, belong to church groups.
	3. Health Resources (including mental health)	
Hostility or bitterness or apathy towards available health resources so great that serious health problems of children do not receive medical care or health needs of parents that prevent them from caring for children are not met.	Family regards health resources with suspicion, hostility, resentment. Agencies used unconstructively, appointments are missed, follow-through lacking medical advice not followed, but not to extent of seriously endangering children's welfare.	Family as positive attitude toward health agencies, available facilities are used promptly when needs arise, appointments are kept, medical advice followed.

4. Social Agencies (including probation, housing authority, employment agencies, etc. as well as casework agencies)

Inadequate	Marginal	Adequate
Extreme hostility to social agencies leading to behaviour such as assault, robbery or destruction of property, fraud, etc. refusal to accept agency services where this has been ordered by law or is necessary because of community concern about children.	Attitude towards agencies marked by hostility, resentment, defensiveness, apathy, etc. Agencies used unconstructively - family is not co-operative, or is apathetic, or overly demanding etc.	Attitude towards agencies is positive. Family utilizes agencies appropriately for improvement of family life or for meeting needs of individual members. Show co-operation in working on joint plans.

5. Recreational Agencies

Hostility towards recreational agencies leads to assault, robbery, destruction of property, etc. Parents prevent children from using organized recreational facilities.	Children seldom use organized recreational groups - as playgrounds, etc. If use is made, behaviour characterized by disruptiveness, non-cooperation, etc.	Family members, particularly children, make use of available recreational resources according to age and interest which provide satisfaction and necessary socialization experience (for children).

APPENDIX IV

A SAMPLE ILLUSTRATION OF SOCIAL WORK INTERVENTION IN THE "INTENSIVE TREATMENT" GROUP

Notes to Appendices IV and V

The actual process of social work can, I think, best be outlined by describing in some detail an actual case. Such recordings were made for all client families and comprise the data from which the second judge rated the outcome of intervention, together with the data format sheets, both pre- and post-treatment.

The two sample illustrations from the "intensive and less intensive" treatment groups were selected from two extreme points of intensity of input into the families. The brevity of the recording of the family in the "less intensive" group shows the minimal level of my participation in this family's task achievement process.

A description of work done with Krishnan and his family

Background to the family situation

This family lived in a chronic state of financial instability. Monthly expenses exceeded income and they had a debt amounting to S$2,000 (about US$800) which showed no sign of decreasing. Krishnan in addition to his full time jobs did odd job to try to make ends meet. As he had been in prison for some years, he had been of no help to his family. He had been committed under Sec.54 of the Penal Code. This section deals with Secret Society members and provides for an unspecified period of detention without trial. His father who was sixty-three years old had, in fact, been keeping the family going through doing odd jobs and borrowing.

Since his discharge from prison about a year before I first came into contact with the family, Krishnan had been occupied firstly with getting a job and secondly with keeping it. He drank heavily and his role within the family seemed to have stopped at just being the provider.

His wife Leela aged twenty-nine years suffered from epileptic fits and was not receiving regular treatment. His children aged six years, four years and three were undernourished and suffered from inadequate socialisation. This stood as testimony to the problems Krishnan was encountering.

Krishnan was rather cynical of people. His image of himself seemed to fluctuate between seeing himself as a better man than others, in that he felt that he had been framed and thrown into prison unfairly and even then had been able to face it, to a very low image of himself. He kept aloof from the rest in his neighbourhood. Sometimes he explained this by saying that his neighbours were hypocrites and other times by saying that people kept away because he had been in prison.

Krishnan's wife Leela was a rather sickly woman, who suffered from epileptic fits which sometimes left her in bed for several days. On all contacts, her appearance was unkempt; it was quite apparent she took no trouble with herself. She was subdued in her manner, talking only when coaxed and her answers were usually rather non-committal. She said that she had been to various doctors, both modern and folk, for treatment but nothing seemed to help. A very striking observation was that Leela did not once smile. She practically never left her home, as either Krishnan or his father did the shopping. She too, like Krishnan, seemed to have kept away from the neighbours. Her reason was that people looked down upon them as her home, compared to theirs, was shabby.

Krishnan's father, an old man, had taken care of the family throughout the time his son was in prison. In addition to finding money, he had to cook and wash whenever his daughter-in-law had to stay in bed. This man had a very strong attachment to his daughter-in-law which was equally reciprocated by her. During the period

of study, he was the only member of this family who showed discontentment and anxiety for the future. He was the only person who asked me to intervene and help.

Krishnan's children were considerably neglected. His eldest child should have been sent to school as she was six years old, but both Krishnan and Leela said that they had forgotten to send her. The three children seemed under-nourished. They too, like the mother, never left their home. On my initial visits I observed them to be extremely withdrawn and passive, so much so that they seemed to have fused into the walls. They made no noise and just hung around the room.

The flat, in Krishnan's words, was "rather shabby". Though there was no modern or new furniture as in most flats, there was, nevertheless adequate furniture, all purchased sometime ago by Krishnan's father. There was a T.V., a radio and a fan.

The shabbiness came from the unkempt way in which the room was kept. The walls were dirty, clothes and bits of paper were usually all over the floor, chairs were sticky and the room was rather dimly lit.

All in all, this family's functioning level was rather low. Their social and financial circumstances and both Krishnan and Leela's inadequate role-playing seemed to have hampered this family rather drastically, with evidence of great need in both the material and emotional spheres. I felt that they were in need of help but my feeling was that first they would have to be motivated to accept and use any aid offered. Material inadequacies would have to be met to ease the way for any attempt to modify their behaviour. For any sort of long term effects, they would have to be helped to be more aware of their roles, helped to raise their self-image so that at least there was a spark for striving. A vicious circle encompassed this family - Krishnan, his wife and children. The children evolved a very negative feeling in Krishnan. He did not think he could or really should pay much attention to them, other than just feeding them. Krishnan's behaviour

stemmed from his experience of being in prison, the period when he could have learnt most about being a husband and father. He felt rather bitterly about his father having to provide for his family.

The Process of Social Work Intervention

For the purposes of the research no constructive intervention was made initially. However, on visits, Krishnan was urged to admit his child to school, and take his wife for regular medical treatment. In short, areas that needed his or his wife's attention were in appropriate ways pointed out. No in-depth attempt was made initially at enabling change.

When I visited the family again, after the six month from "non intervention" period needed for research purposes, I found that nothing had been done about the child, the wife's situation was as before and my impressionistic observation was that there was no change for the better. However, the old father had taken a turn for the worse and was practically bed-ridden, thus introducing further strain.

By the process of random selection, this family fell into the "intensive treatment" group. A full programme of intervention was planned and implemented.

Both Krishnan and his wife seemed quite indifferent as to whether help was given or not. Several sessions were used, not to do anything in the way of material needs, but just to draw them out, enabling them to talk of their feelings, their needs and their problems. The purpose was to get them interested in what was happening to them. Very often I had to take an aggressive approach to pull them out of their apathy. After three weeks, the relationship reached a stage where all three of us sat down to list what had to be done.

Two lists of tasks were drawn up - one listing things to be done as seen necessary by the client and the other listing things as necessary by me.

Client's List	My List
Relating to Children:	
1. Child to be admitted to school.	1. School admission, nutrition and children.
Krishnan:	
2. Krishnan's citizenship to be followed up.	2. Build up Krishnan's role as a husband and father.
3. A steady part-time job to be obtained for Krishnan.	3. To control his drinking.
	4. To control his tendency to withdraw from neighbours and to quarrel.
	5. To raise his self-image.
Relating to Leela:	
1. Leela's identity card status to be examined.	1. To ensure regular treatment at the clinic.
2. Leela to see a doctor.	2. To draw her to speak more freely of her needs and feelings.
	3. To motivate her to have more interest in herself, her home and children.
	4. To widen her social contacts.
	5. To enable her to participate more actively in the marital action block.
Father:	
1. As regards the elderly father, they just couldn't think of what to do, although they felt that something should be done.	1. To be taken to the hospital for due medical attention.

Client's List	My List
	2. To explore the possibility of Public Assistance to help family tide over the extra expenses involved.
	3. To provide a regular sum of money to meet the elderly man's needs.
	1. All members of the family to be educated on their rights and methods of utilising social services.

Thus, Krishnan and Leela had come to the point of recognising some of their material needs and could now talk about how to meet them. No emphasis was yet made on encouraging insight or on working on those areas. Although their material needs could have been quite easily remedied by myself without their active participation, I decided that they must be brought into the process of obtaining needed material improvements more actively. This I believed would expose them to some social resource systems and encourage them to take what was theirs in the rightful way. It would also prod both Krishnan and Leela to get out of their home, to organize their time and children, and to keep appointments. More importantly, however, it was a learning experience, in the hope that once my active intervention was terminated they would be able to use resource systems in the future with some degree of confidence.

In order to get their child admitted to school, to pursue their citizenship application, they had to have the necessary documents. All these were hidden away in some old boxes of odds and ends. A whole afternoon was fixed to sort these out.

All three of us sat down with boxes and bags and went through each, discarding whatever they thought should be thrown out. I provided them with a file in which to keep all important personal documents and correspondence. We taped torn certificates and papers, and smoothed out crumpled birth-certificates. At the end of the afternoon we came up with a bag full of stuff to be thrown away and a complete file of necessary papers.

The wife participated quite actively in the whole process, muttering often that had she known how to read English, like her husband, she would have sorted this out a long time ago. The immediate result here was quite readily seen by all. Some form of order and tidiness was established in one nook of this home.

The next thing to do was to take Krishnan's father to the hospital. An appointment was made, an ambulance called and the father, Krishnan and I went to the hospital. There I was told that the father had been brought in five months ago, was hospitalised and was told to return for regular treatment but had not turned up since. I consulted Krishnan who said this was true and they had not returned for he was not as yet able to pay the hospital bill of S$200 (about US$80) and further could not manage to bring his father to hospital as the father could not walk. I took Krishnan to see the doctor and asked him to tell the doctor his story. The doctor said all Krishnan had to do was to have said so for it could have been arranged for Krishnan to collect the medication and the medical social worker could have been asked to look into the financial problem. It was observed that Krishnan did look surprised for he did not expect this and had obviously stayed away fearing pressure to pay. However his father was admitted to the hospital and the doctor indicated that he would have to stay in hospital for some time. This in a way removed one source of tension in the home. I then took Krishnan to speak to the medical social worker who agreed to arrange for payments by instalment and if the old father became eligible for public assistance then all charges would be waived.

At the end of this whole process, Krishnan cheered up. He spoke quite rapidly and said that he should have known better than to stay away. After all his father must have suffered. He then rationalised by saying how was he to know that the government would actually help and that he was never alllowed to see the doctor before. This was the first time he had "reflected".

This same process was applied to checking on Krishnan, and his wife's citizenship applications. His father was given public assistance and it was agreed that Leela should collect it monthly at the nearest community centre. Leela was rather apprehensive. I urged Krishnan to take his wife to the community centre and show her how to collect the money. While this was being discussed Krishnan asked quite frankly whether the reason for my asking that his wife should collect the money was that I was afraid that he might drink it away. I said yes to this and he smiled. His wife laughed and said that he wasn't able to cheat me as he did her. And they laughed.

Krishnan's wife and child were then taken to the school and the child was registered. I then took the wife to buy the child's uniform and books, having obtained money for this from a fund. All the way to the school and shops, I engaged the wife in conversation. She talked about how she should have learnt all these things. She wished she knew English. I pointed out to her that she managed quite well with the school principal and shop keepers in Malay so really she had no problems. She then worried about how to send her child to school, and I assured her that I would again take them down to familiarise them with the route. I suggested also that lots of children from their block went to the same school, could she not ask around, so that she could save herself the trip. She hesitated at this. She said she really didn't know anyone. I told her that I would find out who went there then she could talk to them. She still did not seem happy.

I told her that I couldn't really ask for her for they would like to know who she was and so on and thus it would be more friendly on her part to do it. She just nodded.

It was at this stage that Leela joined the Women's Group, and it was through her participation in this group that she finally asked one of the other members to help take her child to school. The member responded by having one of her children going to the same school pick up the child. Leela needed a lot of encouragement and support to participate in the group. She was anxious and silent when attending group sessions. Fortunately as the community was basically a very friendly and accepting one, the other members of the group received her warmly.

Throughout this period of fairly intensive work with the family Leela looked better in appearance. Having to leave the home, she had to dress properly and comb her hair. Though traditionally all married Indian women have to put on the "tilak" (a red spot) on the forehead, she never had one until now. The home too took on a semblance of tidiness. I had also taken the opportunity of the child going to school to emphasise the need to send the child clean and tidy, and the need to help the child keep her books in good condition. This I explained to the mother would help the child to be accepted by her teacher and peers. Leela did make a good attempt. Her children in general looked cleaner.

It must be stated at this juncture that all these actions towards the goals set were not done in isolation. They were planned to be done and were implemented simultaneously.

The school-going child of course posed a problem. The principal and teacher took turns to call to complain of the child's inability to cope with work and her restlessness. Several visits were paid to both. The child's background was explained in detail, and I sought their co-operation and patience. I explained what I was aiming to do, and told them

that soon in the afternoons the child would join a group of children and a worker would pay enough attention to help the child to integrate with the group. It has to be stated that in this case both the principal and teacher had to be given support and sympathy and their co-operation had to be secured, although this in itself was quite a difficult and time-consuming task.

Special attention was paid to ensure that Krishnan was aware of all that was going on with his children and all that his wife had to do. Most matters were discussed with him, leaving him to make suggestions and decisions. Keeping appointments with me, forced him to be home. It was only on a couple of occasions that he was late and tipsy for which he apologised profusely. These discussions of family matters were increased. More frequently, Leela was drawn in and she too began contributing to them more actively. But still, as yet, no open mention was made of any specific inadequacy or behavioural goals to be achieved.

If the children's needs were to be met, hygiene and nutrition had to be discussed. An open approach or aggressive techniques would have only served to retard the working relationship at this stage and would have done no good to building self-image. An opportune moment had to be awaited. This came in the form of the teacher's complaint that the child dozed off in class frequently. I discussed this with the mother, and informed her that from my information in the schedule I noticed that the children had breakfast only occasionally. I explained to her that if the child was hungry, it can't really be energetic. To this she said that none of them had breakfast and they were used to it. A detailed explanation then on children's and adults' nutritional needs ensued. I explained the input and output of energy. Furthermore, I pointed out to her that children had lice in their hair and this would further drain them of energy. To all these, she listened carefully and then said that she often felt tired in the morning and sometimes had little money to spare to buy bread and food. From here on, we discussed ways of managing

money, bulk buying, i.e. for monthly and not daily needs as was the practice. I drew on nutrition as a casual factor for her tiredness too, and discussed with her the cheap but nutritious foodstuff, pointing out the advantage of her going to the market for then she could browse around and buy, instead of Krishnan rushing in for ten minutes and picking stuff up. I further explained to her that one could take the children to the government clinic to have them treated for lice. It wouldn't cost much and it would be a great relief to them. She said she too would like to get the treatment as she had the same problem.

A lot more was covered in this session, the use of soap and it doubling as shampoo, the need for children to have regular baths, meals and hours of sleep, the need to keep a clean kitchen and linen. I did not forget to add that so much could be expected from her as she could get ill. However, on her well days she could cope and the children be trained to take care of themselves so as to ease her burden of chores.

These things were pursued only because signs of reception to such discussions and motivation had been indicated and observed by me. Further, these aspects were being simultaneously discussed in the women's group. The first two children were then taken to the play and study group which was started in the housing estate by me. The worker there was briefed on their background and special needs. During the first two weeks both the children found it rather difficult to settle and adjust. This group was of a mixed age ranging from thirteen to seven. I myself was present at these group sessions which were held three times a week, to work with the children with special needs, while the worker concentrated on the others. The plan was to give attention to the children with special needs so that they would adjust and integrate into the larger group which would be conducted by a para-trained worker. The second child, a boy, who used to run down to the shops frequently to buy his father's cigarettes and beer, adjusted more quickly than the eldest girl.

She fluctuated from being absolutely withdrawn to moods of extreme restlessness. My work with this child was not only in the context of the group but also on an individual basis in the background and sitting on the steps of the flats. She would come with me obligingly but would remain silent throughout, even rolling and playing with her on the grass patch brought forth no sound till a very much later stage.

The children who until now had been homebound, now had some outlets. School and play group allowed them to give vent to their restlessness and exposed them to other children, and noticeable change was observed. No longer did the children sit quietly withdrawn against the walls. Shouts of "Aka Aka" (sister) greeted me on subsequent visits. The oldest child did start talking, though she did this with much difficulty, long pauses, heavy breathing and sometimes, stammering. I urged Leela to use the afternoons on which her children were away to rest or do her chores. These afternoons also provided Krishnan and Leela with privacy, for Krishnan sometimes came home at 2.00 p.m. from work.

The first family members to respond to intervention were Leela and children. Their sulky silence was gradually diminishing. Krishnan, however, wasn't very consistent. He had to be often urged to do things. Leela and the children were taken to the clinic for delousing treatment, and his wife's epileptic fits were also explained to the doctor who prescribed regular and long term medication to control them. He explained in detail that such fits couldn't really be cured but only controlled. As the clinic was some distance away, Leela felt she couldn't really make it there all by herself as yet, and I decided to ask Krishnan whether he could arrange to take her there. This was the first occasion when the wife actually asserted herself with her husband. Krishnan started off by saying that he couldn't promise and anyway it wouldn't do much good, remembering past experience and so forth. To this she actually got angry and said that she couldn't really cope with being ill and all she was asking him was to help till she could manage

herself. She also said that she now realised that it was time he paid more attention to the family and not carry on as in the past just because she had, so far, been so quiet. Krishnan did look uncomfortable (probably as I was there), however, slowly a look of amusement crept over his face. Then in Tamil he said something to this effect "has her ladyship said enough, may I speak now" then he turned round to me and said "my wife has now learned to talk". It was difficult at this stage to gauge whether he resented it, or resented me as being responsible for it or whether he was truly amused.

Throughout the period of intervention, visits were made to ensure consistency and persistence in working at the newly established pattern of communication and relationships. The small child was still in school and she and her brother attended the group regularly. Leela was urged to ensure that her visits to the clinic were made regularly. Towards the end of this period of intervention, I informed them that I would soon have to leave, but would re-visit them on my return from Hong Kong. The worker at the play centre had by now become familiar with the children and she would keep in touch with this family.

However, I asked Krishnan to keep an afternoon free as I would like to discuss some matters with him before I left. This was the only occasion on which Krishnan was drawn into looking at himself and his family, and I went over the ground with him. I encouraged him to speak out on his role in the whole process, and pointed out how easily he took some decisions and even worked at them. Did he notice the change in his wife and children? Krishnan listened, but then said that he couldn't have done all these by himself. His father, his children and wife, all had to have dealings with other bodies, he would not have known how to go about it. I agreed with him and said that it would have been difficult for him to locate resources. However, now that things were on a slightly more even keel, could he not sustain them?

I pointed out too that there were some areas where only he could help himself and his family. For example, one was merely to spend more time with them so as to know how things were. He insisted that money was an important factor, and he had to work very hard. I agreed to this and explained that I was very aware of how tight their purse was. This he could help by organising his budget; his wife now had a fixed amount for housekeeping and he could also fix amounts for essentials and try to have less drinking bouts. He again would not need money to take his wife and children to walk down to the nearby park or to participate in the Temple activities. He, as much as them, needed a change from home and relaxation. It was important for him and his children to strengthen their relationship. This was quite a long session with Krishnan actively participating. There were long silent pauses. When talking of what he could not do for the family, Krishnan wept but regained by saying that he was trying his best. His perspective of what he should be was looked at with him. He did show that he understood why he had to do more than just provide money. There were no promises made, no decisions taken at this session. It came to an end with both Krishnan and me not saying very much towards the end. Krishnan did certainly seem less aggressive and more interested. He had his usual rationalisation but there were times when he paused and nodded.

It may sound philosophical at this point, but Krishnan's usual gregarious outbursts and wave of hand to show disinterest had actually given way to bowed head and occasional nods. Could this be interpreted as understanding? Such understanding that usually subdues us?

APPENDIX V

A SAMPLE ILLUSTRATION OF SOCIAL WORK INTERVENTION IN "THE LESS INTENSIVE" TREATMENT GROUP

A description of work done with Bala and his family

Bala lived with his wife, his mother and six children in a one-room flat.

This family had severe problems with money management. They had a debt of S$1,700 and monthly expenses often exceeded income.

In most areas of social functioning, the family was coping adequately. Though the couple had six children, Meera, having tried contraceptive injections, had given up because of their side-effects. Thus though still in the child-bearing age, neither the wife nor the husband was practising any form of contraceptive behaviour.

The process

This family possessed the potential to act but were held back from achieving an adequate level of functioning by mere lack of knowledge as distinct from motivation. As they were open and receptive to intervention not much was demanded in terms of case-work input.

The woman was invited to join the Women's Group where social resource systems and contraception were dealt with.

In the area of contraception, the woman responded positively and quickly. She learnt of the different methods of contraceptions, discussed them in detail with me during my visits to her home, then went along to the Family Planning clinic and fitted herself with an IUD.

She was the woman who had initiated some members into going with her to a low cost supermarket where staples could be bought cheaply. Towards the end of the treatment period, she managed to keep expenses within income by simply reducing her grocer's bills. This did not help to clear debts but served to help her from increasing them.

With this family no intensive counselling was done - their need was for more information as regards resource systems and when they got it, they utilised it to improve their situation.

SEAPRAP

THE SOUTHEAST ASIA POPULATION RESEARCH AWARDS PROGRAM

PROGRAM OBJECTIVES

* To strengthen the research capabilities of young Southeast Asian social scientists, and to provide them with technical support and guidance if required.

* To increase the quantity and quality of social science research on population problems in Southeast Asia.

* To facilitate the flow of information about population research developed in the program as well as its implications for policy and planning among researchers in the region, and between researchers, government planners and policy makers.

ILLUSTRATIVE RESEARCH AREAS

The range of the research areas include a wide variety of research problems relating to population, but excludes reproductive biology. The following are some examples of research areas that could fall within the general focus of the Program:

* Factors contributing to or related to fertility regulation and family planning programs; familial, psychological, social, political and economic effects of family planning and contraception.

* Antecedents, processes, and consequences (demographic, cultural, social, psychological, political, economic) of population structure, distribution, growth and change.

* Family structure, sexual behaviour and the relationship between child-bearing patterns and child development.

* Inter-relations between population variables and the process of social and economic development (housing, education, health, quality of the environment, etc).

* Population policy, including the interaction of population variables and economic policies, policy implications of population distribution and movement with reference to both urban and rural settings, and the interaction of population variables and law.

* Evaluation of on-going population education programs and/or development of knowledge-based population education program.

* Incentive schemes — infrastructures, opportunities; overall economic and social development programs.

SELECTION CRITERIA

Selection will be made by a Program Committee of distinguished Southeast Asian scholars in the social sciences and population. The following factors will be considered in evaluating research proposals:

1. relevance of the proposed research to current issues of population in the particular countries of Southeast Asia;
2. its potential contribution to policy formation, program implementation, and problem solving;
3. adequacy of research design, including problem definition, method of procedure, proposed mode of analysis, and knowledge of literature;
4. feasibility of the project, including time requirement; budget; and availability, accessibility, and reliability of data;
5. Applicant's potential for further development.

DURATION AND AMOUNT OF AWARDS

Research awards will be made for a period of up to one year. In exceptional cases, requests for limited extension may be considered. The amount of an award will depend on location, type and size of the project, but the maximum should not exceed US$7,500.

QUALIFICATIONS OF APPLICANTS

The Program is open to nationals of the following countries: Burma, Indonesia, Kampuchea, Laos, Malaysia, Philippines, Singapore, Thailand and Vietnam. Particular emphasis will be placed on attracting young social scientists in provincial areas.

Applications are invited from the following:

* Graduate students in thesis programs

* Faculty members

* Staff members in appropriate governmental and other organizations.

Full-time commitment is preferable but applicants must at least be able to devote a substantial part of their time to the research project. Advisers may be provided, depending on the needs of applicants.